Pharmacists Look Ahead
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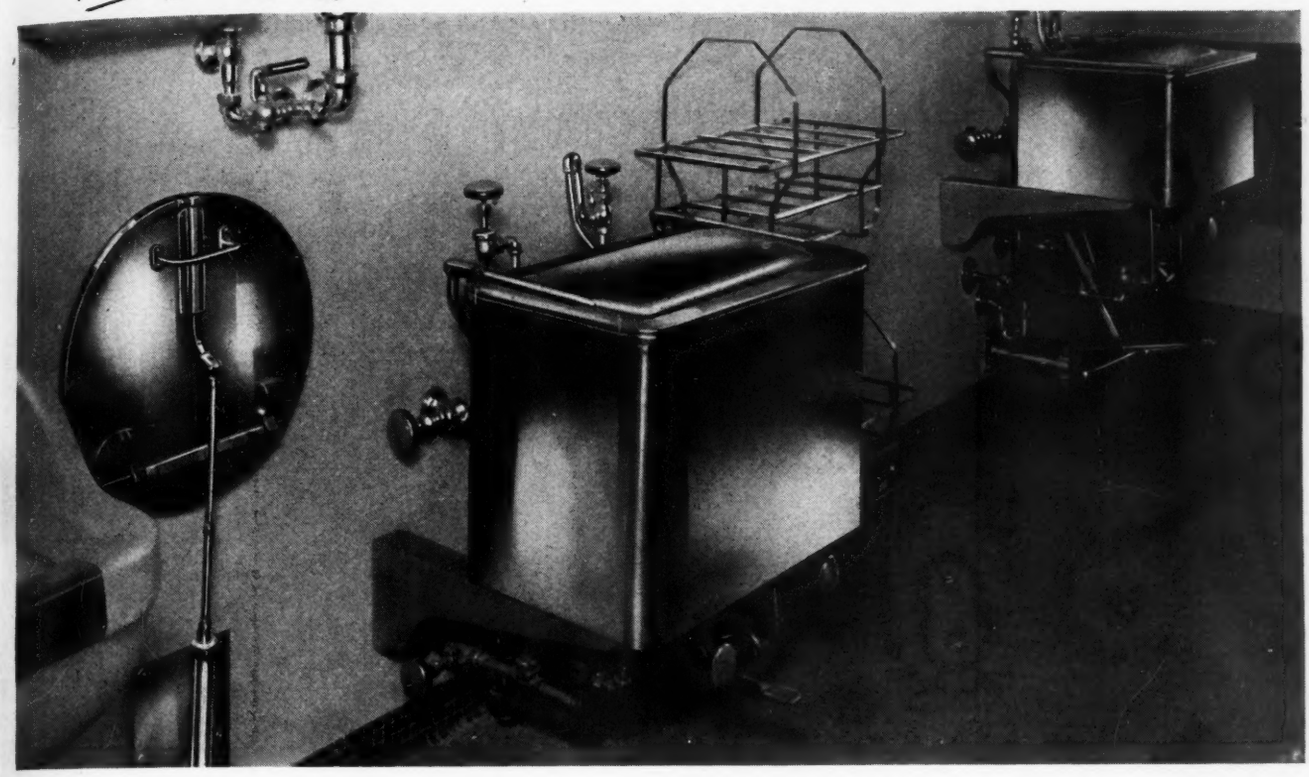
the MODERN HOSPITAL

VOLUME 63 OCTOBER 1944 NUMBER 4

CORRECT ANALYSIS
means
Better Sterilizing Service

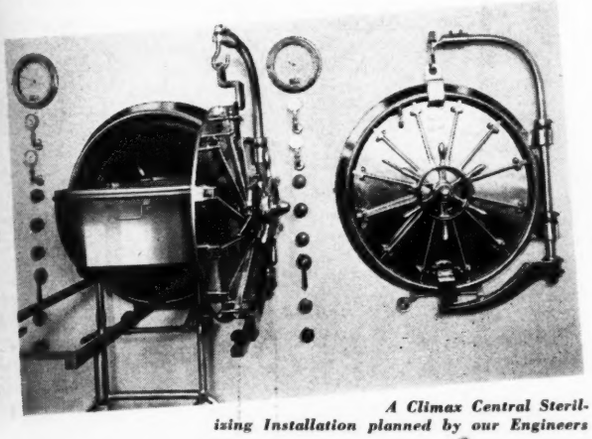


Utility Room in one of New York's newest hospitals

Put Your Sterilizing Problems Up to Men Who Know!

Because they were expertly planned, built and installed to meet the exacting needs of the particular projects, our Climax Sterilizers are giving completely satisfactory service to hundreds of hospitals all over the country.

All the experience that is back of these successful installations is yours to employ. Our Engineering Department can help you solve your sterilizer problems by giving you, early in the planning stage, advice on technical and engineering problems, roughing-in measurements, detailed layouts, specifications, etc. Such aid, provided in time, will enable you to secure a correct analysis of your problem and so assure you of better sterilizer service. This expert service is yours without obligation.



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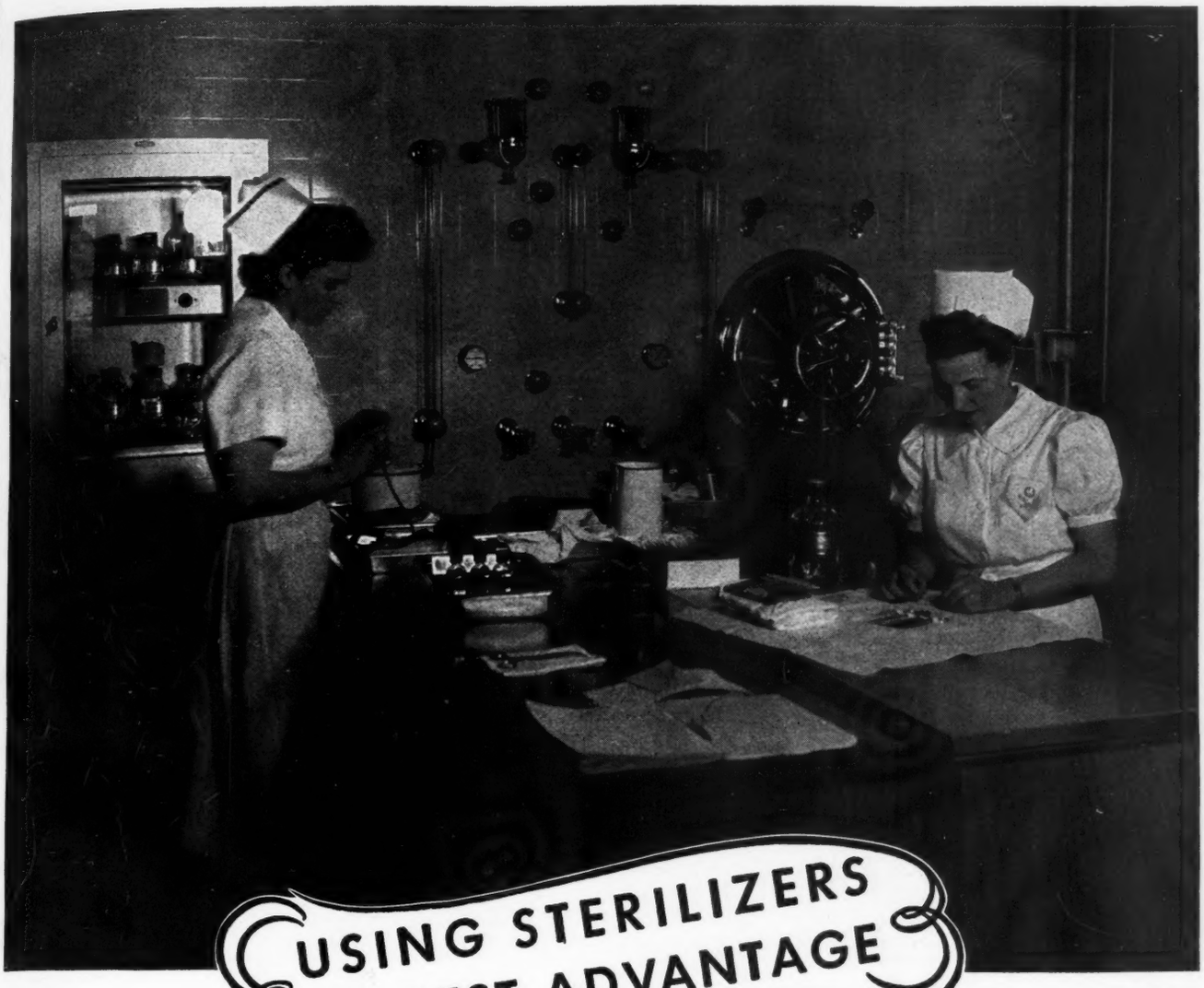

USING STERILIZERS TO BEST ADVANTAGE

Expansion of hospital service to meet increasing demands for hospitalization often necessitates additional equipment. The best use of this equipment should be considered at time of installation. "Central Service" is an efficient arrangement for preparing and distributing sterile supplies, and results in maximum economy of materials, and best use of personnel and apparatus throughout the hospital.

Above: Central service room at St. Joseph's Hospital, Elgin, Illinois, equipped with Scanlan-Morris autoclave, pressure water sterilizers, and solution warming cabinet.

Our engineering and planning department will gladly assist in arranging for central service or other facilities to expedite hospital work.

Let us send catalogs of surgical sterilizers, bedpan apparatus, surgical tables and lights, delivery room and infant equipment.

ARMY E NAVY

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Manufacturers of
STERILIZING APPARATUS AND HOSPITAL EQUIPMENT
OPERAY SURGICAL LIGHTS AND SCANLAN SUTURES

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THE ROVING REPORTER

Art for Health's Sake

Increasingly we hear of music therapy but art therapy is a newer notion, except as work in the crafts has been incorporated in occupational therapy. A British artist has recently been doing rewarding work in hospital wards in both art appreciation and art tuition.

It seems a little odd (we have the word of *Hospital and Nursing Home Management* for it), but to hang a picture in a British hospital is strictly *verboten*. Judging from some of the depressing chromos sometimes seen in our own institutions there may once have been sound reasoning behind the regulation. Apparently, no British physician today upholds such an unenlightened rule yet the restriction still holds.

Adrian Hill started art therapy work in the King Edward VII Sanatorium at Midhurst. His work in that institution attracted the attention of the British Red Cross Society and recently the scheme has been launched in various types of hospitals in the Greater London area.

In the art appreciation phase, Mr. Hill at first would take an appropriately framed reproduction of a good painting into a patient's room or a ward, stand it on a chair, give a ten minute analysis of the work and then carry it out with him. Later he tried sticking an unframed print on the wall with adhesive tape and letting it stay up a little longer before shifting it to another ward. As the patients' appreciation grew, he noted how they turned more and more toward modern art.

When it comes to creative work in art, Mr. Hill gives the patients a little talk or two on picture making, presenting it as a means of relieving the tedium of their illness and of turning their thoughts to a prospect not associated with their disability. They are taught not to expect to produce a finished product having esthetic value but merely to enjoy a happy occupation.

If the patients are not able to take up pencils or brushes, they like to hear Mr. Hill talk about some aspect of picture making or to look at large prints of the old masters or of contemporary artists. Once they are able to sketch or paint he starts instruction.

Recently Mr. Hill has organized a monthly sketch competition. He announces a subject, such as "Spring Morning" or "Rest Hour," and gives the date when entries will be collected. The sketches are then placed on exhibit in the recreation room and are criticized in the presence of the ambulatory patients. Drawings by "bedders" are in a different class but little prizes are given for these, too.

The art therapy project is said to be meeting with a measure of real success.

This Ad Pulled

You know the problem—not enough help to give patients the standard of care and of living conditions to which the taxpayers' money and the state of their health entitle them. Most hospital folk can appreciate the predicament, especially in a state institution for the mentally ill. Help Wanted columns didn't pull, not as long as regular want ads were run. But the superintendent of Springfield State Hospital, Sykesville, Md., was struck with an idea. He ran the display advertisement shown below.

You Can Have $70 Free Cash

at the end of each month!

Essential Hospital Work for white girls and women—
Absolutely no experience necessary

Your monthly salary	$77.50
Minus average withholding tax	6.50
Expense for room	None
Expense for meals	None
Expense for carfare	None
Expense for laundry	None
Expense for work clothes	None

Apply Supt., Springfield State Hospital, Sykesville, Md.

The investment paid off and for the first time the hospital was able to compete successfully with industry and business for the available womanpower.

Undisputed right of way

A screaming siren . . . a clearing right of way . . . a speeding ambulance . . . a race against time . . . quickly . . . safely . . . dramatically . . .

IN THE delivery room, 'Ergotrate' (Ergonovine Maleate, U.S.P., Lilly) is given undisputed right of way among oxytocic drugs. Its therapeutic efficacy in this field is due to its quick, safe, dramatic, and uniform action on the uterine musculature, producing an immediate and sustained contraction.

TABLETS 'ERGOTRATE' • AMPOULES 'ERGOTRATE'

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A. *Lilly*

INVEST IN AMERICA • BUY WAR BONDS

New Service for Fathers

Progress reports by loud-speaker reach expectant fathers in their watchful-waiting room at California Hospital, Los Angeles.

"Mr. Thomas! Mr. Thomas! Your wife has entered the delivery room. Everything is just dandy. Normal in every way. Relax now. Don't worry. Stand by for further announcement."

Mr. Thomas' face lights up. He smiles encouragingly at Mr. Stefani, who wears the same beaten look Mr. Thomas displayed a minute earlier. Soon it is Mr. Stefani's turn.

"Calling Mr. Stefani! Calling Mr. Stefani! Your wife is entering Delivery Room No. 2. She is smiling and cheerful. How are you doing, old man? Take it easy now."

Mr. Stefani smiles back at Mr. Thomas. They even arrange a little wager as to which will become a parent first. One lights a cigaret for the other. The hands of both are steadier now.

Still the minutes drag. They look wearily at the clock, expectantly at the loud-speaker.

"Attention, Mr. Stefani! Listen carefully now, very carefully."

From the loud-speaker comes a sharp smack, followed by a lusty wail.

"Congratulations, Mr. Stefani," comes a hearty voice. "You are the father of a fine boy. A football star, if I'm any prognosticator."

Mr. Stefani walks on air out of the waiting room. He has gained a full inch in stature; he is the father of a son. He has forgotten all about Mr. Thomas and the wager.

All This and Publicity, Too

This is a follow-up on a hospital garden story. You may remember this Reporter's account of the Egleston Demonstration Garden, a joint project of 75 garden clubs in the area around Atlanta, Ga.

The idea was that of the president of the Peachtree Garden Club, Atlanta, and she took it to the Henrietta Egleston Hospital for Children in Atlanta where it was accepted happily.

Experienced farmers in the vicinity said the clubwomen couldn't raise 50 cents worth of vegetables on the worn-out soil of the hillside acre belonging to the hospital. The plot had once been a dumping ground and when the women took it over it was just red clay, big exposed rocks, litter and underbrush. Worse still, there was a 20 foot drop from one end of the garden to the other.

By the end of the summer the farmers had to eat their words for the 60 little patients at this children's hospital and the nursing staff and other employes have been fed green vegetables from this garden all through the summer and a full winter's supply has been canned. At times there were bushels of tomatoes, squash, eggplant, peppers and corn in excess which were sold.

The hospital gained all that and publicity, too. The community gained even more, for citizens learned how other eroded areas and worn-out soil can be made to produce richly.

First the ground was cleared of all growth and rock, plowed deep and laid off in 12 terraces with a drop of 2½ feet to each succeeding terrace.

Forty truckloads of fertilizer were put on this scant acre and a winter crop of Austrian peas was planted. Last spring the peas were chopped fine and plowed under and additional fertilizer applied. Then the garden was ready for planting.

Because of proper terracing, not one spoonful of soil was lost even during the hard spring rains. Drought came in mid-summer but a trench system of irrigation had been installed and the vegetables kept on growing and producing. All the work of cultivating during the summer was done by one gardener.

The clubwomen not only have demonstrated to the community the raising of every kind of vegetable known to the South but have planted strawberry

vines, raspberry plants and a number of fruit trees that are expected to bear in due course.

A Blow to Romance

To make the punishment fit the crime, violators of telephone rules at Queen's Hospital, Honolulu, Hawaii, have been threatened with publication of their names in the institution's house organ, the readers to serve as a jury.

A nurse held up one of the hospital's precious trunk lines for ninety-seven minutes recently while she talked long distance to a friend at a military post.

The telephone company wrote a sharp letter to the hospital naming the young lady who had put in the call from a dial phone in the nurses' residence and requesting that steps be taken to prevent such abuse of company facilities. The company pointed out that its lines were an integral part of the military system of the Islands and that a call to an Army post tied up a trunk line that was badly needed.

The hospital instructs telephone operators to give warning to persons who talk over the three minute limit and if the warning is not heeded to disconnect the line. This becomes more difficult to do when the calls are made by automatic dialing from the nurses' home. However, operators have been again instructed to cut in and cut out on chatterboxes.

Inter-City Emergency Service

The emergency service of Berkeley Hospital, already serving the city of Berkeley and the North and West areas of Oakland, Calif., has recently been extended through an agreement with the city council of Albany, Calif.

Berkeley Hospital will now give first aid and emergency care without charge to any person injured within the city limits of Albany or to residents of Albany injured beyond the city limits, provided they are brought immediately to the hospital as emergency cases either in the police ambulance or in their own cars. Indigents will receive twenty-four hours' hospitalization without charge.

The hospital keeps an emergency surgeon and nurse on duty at all times. Following emergency care the patient is referred to his family doctor for such additional care as may be indicated.

Last year this 100 bed hospital handled 6000 emergency cases and under the new agreement with Albany the 1944 records will show a marked increase over the 1943 figures.

Berkeley's emergency service had its true test the night of the Port Chicago explosion. Its disaster organization was immediately activated and the additional beds and hospital equipment provided by the local defense council and the Red Cross were quickly set up. The volunteer staff was on the job in a twinkling and the preparedness plan, devised early in the war, functioned efficiently.

Self-Screening Device

Aptitude tests are good and every principal of a school of nursing has pet screening methods of her own, but still there are many drop-outs among the probationers.

A self-screening device that has worked out reasonably well in a number of institutions is exemplified at Paterson General Hospital, Paterson, N. J. The local high school principal and teachers in conference with hospital and nursing school executives have cooperated in working out a plan under which potential nursing students work part time in the hospital as ward helpers.

Paterson started calling these girls the Victory Cadet Corps and some of the first group later became successful members of the U. S. Cadet Nursing Corps when they entered the school of nursing. Others, finding nursing chores not to their liking, have turned to other fields and thus teaching time and student accommodations have not been wasted on girls who would not have made a success of a nursing school career had they started in "cold."

C is Sensitive

Therapeutists are interested in many-sided ascorbic acid (vitamin C). They are inquiring especially into its parenteral injection in the form of sodium ascorbate solution.

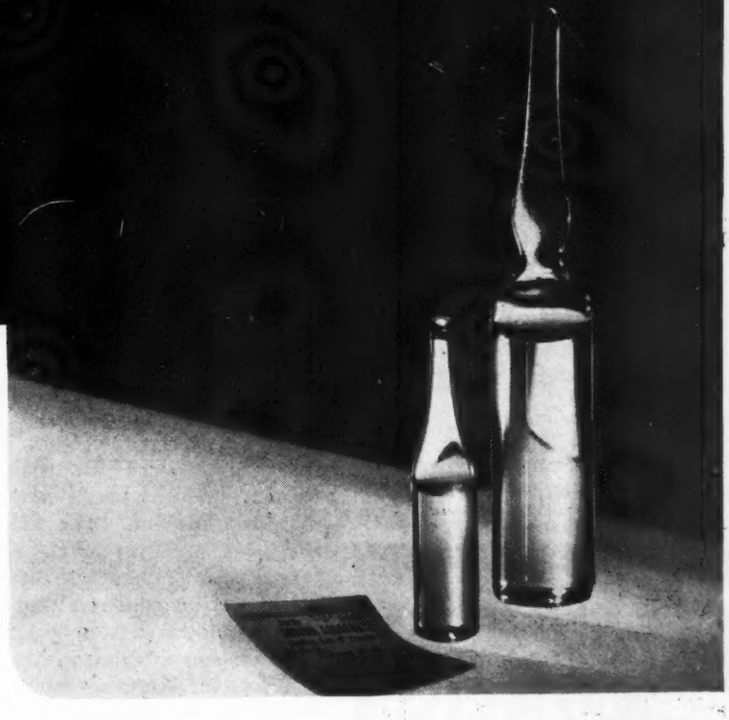
But sodium ascorbate is sensitive and should be protected. It is harmed by more things than most vitamins—by a closer approach to alkalinity than pH 6; by oxygen; by even traces of metals.

Sodium Ascorbate Solution-BREON is protected

Both during preparation and in the reasonable life of an ampul, significant decomposition of the substance is *effectively* prevented. Tests show it retains 98% of its potency after a year. Sodium Ascorbate Solution BREON remains brilliant, suggesting that it is worthy of your confidence and your use.

This concentrated form of the [illegible] essential is injected parenterally without [illegible] persistent vomiting [illegible]

BREON



In 2 cc and 10 cc ampuls of 50 mg. per cc for intravenous and intramuscular injection

READER OPINION

Address for Captain Klicka

Sirs:

My address is now 5th General Hospital, APO 350, c/o Postmaster, New York, N. Y. The Army is still hard pressed for doctors as we who are working in a general hospital in France can assure you. We don't have anything that one could describe as spare time. I am on the surgical service and keep going an average of fourteen to fifteen hours daily. It is interesting work, however, and the results we are seeing are very gratifying.

Capt. Karl S. Klicka, M.C.

Passes "Neptune" Test

Sirs:

We were tremendously interested in the article, "Escape—Navy Nurses Learn About 'Lung' Training," in the April issue of The Modern Hospital. Our son, Jack, received his certificate testifying to his successful descent into the realm of Neptune at New London. He is now a submarine officer stationed in the farthest outpost and cross the date line.

Albert G. Hahn
Administrator
Protestant Deaconess Hospital
Evansville, Ind.

Efforts Are Appreciated

Sirs:

When I opened the August issue of The Modern Hospital and spied the "Community Hospitals" section, I just had to take time out to glance through the pages of this section. It is splendid. In fact, it is just what I need at the moment to back up one of my enterprises.

Thank you so much for all this valuable information. It is worth more than the extra time I will have to remain on duty to catch up with the tasks at hand.

Thanks to the U.S.E.S., I can't find a laboratory technician who can obtain a letter of availability to accept the position in our laboratory; hence, I am the laboratory technician and have been since April when the technician left without notice while I was attending the Iowa meeting. The U.S.E.S. penalized her, or so it reported, two months for leaving without its approval but she has written differently to one of the other employes so I am uncertain as to the status that was given her. . . .

I, for one, certainly appreciate Will Ross's efforts in behalf of the woman hospital administrator and the advisability of her living out and leading a normal life like other professional people. Of course, that is a bit too idealistic during these times of shortages in every department but, certainly, it is to be desired and something to be attained in the future.

I hope I am not implying dissatisfaction with my lot in life. I feel quite the contrary and enjoy the challenges for improving hospital care and standards but I think that these goals can be reached without the hospital superintendent's having to feel guilty if she takes time out to drink a pink ice cream soda, don't you?

Lilyan C. Zindell
Administrator
Atlantic Hospital
Atlantic, Iowa

More on the Contest

Sirs:

The two architectural competitions that you are sponsoring should stir up considerable interest in hospital architecture and be very beneficial to the hospital field.

We ought to be doing a lot of thinking along the line of tying up hospital function with physical plants designed to serve that function. You are moving in the right direction through your sponsorship of this competition. I shall be glad to do everything that I can to promote the idea.

F. G. Carter, M.D.
Superintendent
St. Luke's Hospital
Cleveland

* *

Sirs:

The architectural contest is most timely and will be beneficial in view of the anticipated increase in new buildings and improvements in the hospital field.

I was also deeply interested in the article published in the same issue regarding errors that are so often encountered in hospital building. The East Tennessee Baptists have recently concluded a successful campaign (oversubscribed) for $1,000,000 to erect a 200 bed hospital. I gave my copy of the issue to the vice chairman of the executive committee and have requested half a dozen more copies for distribution. This article no doubt will help the committee to avoid many of the pitfalls into which it might fall.

T. H. Haynes
Superintendent
Knoxville General Hospital
Knoxville, Tenn.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Cleaning Nursing Bottles

Question: What is the best technic for cleaning and sterilizing nursing bottles?—W.R.M., N. C.

ANSWER: They are washed with soap and warm water, using an electrically rotated brush, then rinsed with warm water and allowed to drain.

Glass nipple caps are washed with soap and water; the brush is used on them once a week to keep them clear and shining. Rubber nipples are washed with soap and water, then boiled separately for ten minutes.

The formulas are measured into the clean bottles, the sterilized nipples are affixed and covered with the glass caps and then the bottles are processed in a steam sterilizer for fifteen minutes. After cooling, the bottles are stored in an electric refrigerator until feeding hours.—H. J. STANDLER, M.D.

Paid Vacations for All

Question Is it customary for all employes, such as janitors and orderlies, to receive two weeks' vacation with pay after one year of service?—I.M.G., Ill.

ANSWER: In recent years the practice of giving two weeks' vacation with pay after one year of service and one week with pay after six months of service has been extended by most hospitals to include all employes, including janitors and orderlies.

This change has been made partly because administrators seem to feel that these employes desire and merit such a provision and partly to meet the competitive situation in which so many other organizations do provide paid vacations. Unless this is done, administrators feel that they will lose their lay employes.—A. B. M.

Holidays for Hospitals

Question: What are the usual holidays for most hospitals and to what members of the personnel does holiday time apply? How should holidays be alternated? What about office coverage on these days?—E.D.P., Mass.

ANSWER: Traditions regarding holidays vary according to local custom. In the Newton Hospital, Newton Lower Falls, Mass., the following legal holidays are observed: January 1, New Year's Day; February 22, Washington's Birthday; April 19, Patriots' Day; May 30, Decoration Day; June 17, Bunker Hill Day; July 4, Independence Day; September, Labor Day; October 12, Columbus Day; November 11, Armistice Day; November, Thanksgiving Day; December 25, Christmas Day.

The Newton employes' manual states that "time off for these holidays will be determined by each department head. Employes who cannot be absent from their work on the above holidays will be given equivalent time off whenever possible." This is the usual provision, although sometimes it is specified that the time off will be given within seven days of the holiday.

The California State Nurses Association "Schedule of Minimum Salaries and Personnel Practices for Institutional Nurses" provides for only six holidays instead of 11. They are: Thanksgiving Christmas, New Year's Day, Decoration Day, Fourth of July and Labor Day. The schedule adds: "If a nurse is required to work on any of the aforementioned holidays, one day off in lieu thereof is to be granted."

At New Haven Hospital, New Haven, Conn., the following holidays are observed: New Year's Day, Washington's Birthday, Memorial Day, July 4, Labor Day, Thanksgiving, Christmas. The personnel policy provides that a substitute day shall be given to those employes who must work on the holiday. This institution also makes the following provision:

"Those employes wishing holidays not regularly observed by the hospital shall be given the choice of taking that holiday without pay or of working on the nearest holiday which is regularly observed by the hospital. This must be arranged in advance and approved by the department head."

So far as I know, holidays apply equally to all members of the personnel regardless of position, length of employment, salary level or other factors.

In "Hospital Personnel Policies" (Bulletin 219 of the American Hospital Association) the following provision is recommended: "When a hospital recognized holiday falls on a Sunday, the following Monday shall be considered as the holiday."—ALDEN B. MILLS.

Exemption From Taxes

Question: We are a 65 bed nonprofit institution rendering general hospital service. We serve under the E.M.I.C. program and write off between $5000 and $6000 to charity cases each year. Are gifts in money to such an institution subject to exemption under the present federal income tax law?—T.T., Mo.

ANSWER: The Internal Revenue Code provides as follows: "Contributions to a corporation, trust or community chest fund or foundation created or organized in the United States, organized and operated exclusively for religious, charitable, scientific, literary or educational purposes, no part of the net earnings of which inure to the benefit of any private shareholder or individual, are generally deductible for tax purposes within the limitations that are specified in the regulations."

These limitations are 15 per cent of the adjusted gross income for individuals or 5 per cent of the taxable income of corporations.

If you are in doubt as to whether your hospital qualifies under this clause I suggest that you fill out forms 990 and 1023. On the basis of these the Treasury Department will determine your status and you can then advise donors to the hospital. Form 990 is an information return by organized groups exempt, or claiming exemption, from the income tax. Form 1023 is an exemption affidavit for the use of religious, charitable or similar organizations.—J. P. MCDERMOTT.

Work Tables for Nursery

Question: If individual bassinet service is impossible, what is the best type of common work table for the nursery?—A.J.L., Ala.

ANSWER: A common dressing table is used which is protected with a rubber covered pad. A clean cotton "wrapper" is put down and the infant is placed on it for morning inspection and dressing, for doctor's examination or for special treatments, such as hypodermoclysis and venipunctures. At all other times diapers are changed in the infant's bassinet.

The table in use in the new-born nurseries of the New York Hospital, New York City, is an electrically heated monel-topped table. The electrically heated monel surface has not appeared to have any advantages since daily bathing of infants was discontinued.—H. J. STANDER, M.D.

LOOKING FORWARD

News of the Convention

SO THAT all readers of The Modern Hospital may have a complete report on the activities and decisions of the recent convention of the American Hospital Association, this issue of the magazine has been delayed to include a 16 page portfolio of the important highlights. This will be found on pages 65 to 80, inclusive. Hospital people who were unable to attend the convention can quickly bring themselves up to date by reading this résumé.

A Year of Progress

AS PRESIDENT Frank J. Walter turned the direction of the American Hospital Association over to his successor, Dr. Donald C. Smelzer, he could look back with satisfaction over his incumbency. In one way the year had been a quiet one as compared with the more dramatic events of the year that preceded it. But it was a year of solid achievement.

The outstanding event of the year was the appointment of the Commission on Hospital Care to make a two year study of the future of hospital service in the United States. While the financing of this study was an accomplishment of a preceding year, the actual selection of members, organization of the commission and appointment of an executive director were done during the last year. The hospitals will now wish to cooperate fully in the commission's various studies so that the results may be of the greatest value.

The second notable accomplishment of the year was the complete organization of the headquarters staff to carry on the expanded program of the association. With the announcement of the appointment of a secretary to the council on hospital planning and plant operation, all of the councils are now provided with competent full-time secretaries to expedite and assist the work of the various committees.

In addition, there is, for the first time in many years, an adequate staff in the Bacon Library to carry on the program that was outlined by the survey of the library. During the last year the library has begun to catch up on the large accumulation of work that piled up during the period of its starvation.

The cooperation of the A.H.A. and the U.S.P.H.S. was successful in attaining the 65,000 goal in recruitment of student nurses, a notable achievement. An institute on hospital personnel was conducted for the first time and other institutes were continued.

Perhaps most notable of all developments was the change of attitude of the association from a defensive to an offensive position as regards the place of the government in the health picture. Instead of attacking the Wagner-Murray-Dingell and similar bills, the association buckled down in earnest to attempt to solve the basic questions involved. While the first statement of principles has not satisfied everybody, it does indicate that the association realizes the importance of developing a comprehensive program.

The attitude of hospitals toward the work of the association is indicated most clearly by the fact that all but a trifling percentage of members have paid their dues on the new basis and the total membership of the association, institutional and personal, has increased slightly during the year. Ninety-nine per cent of the members believe that the higher dues are a good investment.

Negro Nurses and Physicians

A RECENT survey by the division of nurse education, U.S.P.H.S., discloses that there are now approximately 2000 Negro cadet nurses in 33 participating schools of nursing approved by the National League of Nursing Education. In 1943 there were 1918 Negroes admitted to 32 approved schools. Enrollment in 22 of the schools increased by 10.9 per cent in 1944 over the 1943 figure.

"This increase," states the division of nurse education, "has enabled directors to set higher standards of admission which, in turn, have attracted young women who possess above average scholastic records. Many with one or two years of college credit choose to enter one of the five Negro schools of nursing offering a collegiate program of from four and one half to five years." These schools are at Tuskegee, Dillard, Meharry, St. Philips (Richmond, Va.) and Hampton.

The color bar in the U. S. Army is now being removed and, as we reported in our news recently, one Negro nurse has attained the rank of captain. The Army has officially assured the National Association of Colored Graduate Nurses that Negro nurses will be used both in this country and abroad and that no quota has been set for them.

However, as Estelle Massey Riddle of the National Nursing Council for War Service recently pointed out, Negro nurses still suffer from lower salaries and unequal opportunities for advancement. Hence, Negroes constitute only 3.5 per cent of the country's public

health nurses although they make up 10 per cent of the total population.

Opportunities for Negro medical students and physicians also are definitely inferior to those available to whites. But already one hospital in New York City has become a fully interracial institution, a hospital in Virginia has admitted Negro physicians to its staff and an interracial hospital is proposed for Cleveland.

The bars to equal vocational opportunity are slowly letting down. Before this war is over, substantial progress will undoubtedly be recorded.

As Maine Goes

WHILE the health and hospital pattern of the future continues in nebulous form—a subject of much conjecture and some controversy—it is possible to point to definite trends in the regional organization of hospital service. With little public acclaim, an interesting experiment of this kind has been taking place in Maine under the sponsorship of the Bingham Associates. Simultaneously, the Commonwealth Fund has announced a new program of organization and in Michigan the Kellogg Foundation has contributed to the same end. Looking across the ocean, too, we find in England similar steps being taken toward coordination of existing hospital facilities.

To provide a close-up view of such regionalization in which are revealed its great benefits, its weaknesses and its full potentialities in developing better health and hospital services in rural communities, The MODERN HOSPITAL this month devotes a special section to the work of the Bingham Associates Extension Service in Maine. While not a solution to all the problems that face us, it provides, nevertheless, valuable background material for postwar planning.

Public Relations Marches on

SIGNIFICANT in revealing the steady progress of hospital public relations was the organization of a two day institute on this subject sponsored by the Hospital Association of Pennsylvania at Pennsylvania State College late in August. Despite its occurrence at the height of the vacation period with attendant difficulties in attracting both speakers and audience, some 130 registrants were listed representing 80 hospitals throughout the state, a fact which in itself attests to the great interest in the subject.

Although each institution has its own problems to meet, certain basic principles are common to all—happy relations with the press, proper concepts and interest as exemplified by the governing body, the administration and the professional staff, and a sound program of community service.

The final success of any public relations effort, it was shown repeatedly, is not measured by any single dramatic appeal as much as it is by the consistent performance of loyal supporters constituting a vast chorus of voices in which the community leader and the humblest employe join in accord. If for no other reason than the opportunity it afforded for reiterating this unassailable truth, the Pennsylvania institute sets a pattern for other hospital groups to follow.

A Two-Way Street

THIS magazine has urged strongly that hospitals get behind their Blue Cross plans vigorously and thus ensure the success of the voluntary hospital insurance movement. Evidence piles up day by day that the degree of enthusiasm manifested by the member hospitals is a vital, indeed almost a controlling, factor in the success of the Blue Cross.

Good relations between hospitals and Blue Cross plans, however, is a two-way street. Not all of the difficulties are caused by hospitals that take a narrow or selfish point of view. Blue Cross administrators and trustees should realize fully that they, too, must go halfway.

Some of the criticism that has been leveled at a few Blue Cross plans by hospitals could be avoided if the plans would report regularly and fully on their financial situation, would take hospitals into their confidence about ideas, projects and proposals and would pay on the basis of established charges paid by patients who are not Blue Cross subscribers. Some plans are successfully following all of these procedures. Others should copy them.

A "Dime-a-Dozen"

THE impression still prevails among some less astute hospital executives that we shall soon be enjoying again an employers' market. "Be patient," a superintendent was overheard to remark the other day, "we'll be getting them for a dime-a-dozen before long." Others, without definitely committing themselves, are anxiously awaiting the time when they can get even with recalcitrant and uncooperative workers.

There is considerable danger and lack of vision in such an attitude, even though there is some justification for feelings engendered by unwarranted demands. For too long hospitals have practiced the "dime-a-dozen" policy with consequent inefficiencies and extravagances. The sooner we recognize the fallacy of two inefficient, poorly paid workers performing tasks that might better be accomplished by one who is skilled and suitably rewarded for his efforts, the better.

We don't want "dime-a-dozen" workers in our hospitals. We do want intelligent, skilled, interested and loyal men and women whom we can obtain and hold through such justifiable inducements as good wages, attractive working conditions, congenial living conditions (when necessary), training programs, pension plans and other provisions that constitute sound personnel policies. We want fewer but better hospital employes —better work for better pay.

HEADLINE NEWS

New Public Hearings on War Health Program

WASHINGTON, D. C.—A second series of public hearings on the nation's wartime health program was held by the Senate Special Subcommittee on Wartime Health and Education Sept. 18.

The organized medical profession, industry and labor were represented at the September hearings. Special attention was devoted to the significance of the Selective Service physical examination data, methods of improving the distribution and quality of medical care and hospital planning and construction.

Witnesses at the second hearings included: Dr. Roger I. Lee, president-elect of the American Medical Association; Dr. Walter W. Palmer, chairman of the committee on postwar medical service, American College of Physicians; Dr. John P. Peters, secretary, Committee of Physicians for Improvement of Medical Care; Dr. E. I. Robinson, president, National Medical Association; Dr. Ernest P. Boas, chairman, Physicians' Forum; Dr. John R. Boling, president, Florida State Medical Society; Dr. Victor Heiser, chief medical consultant, National Association of Manufacturers; Dr. Leverett D. Bristol, chairman, Health Advisory Council, U. S. Chamber of Commerce.

Van Steenwyk Urges Four Point Plan to Extend Blue Cross Coverage

A four point program designed to extend Blue Cross protection to every man, woman and child in America is being urged by the Hospital Service Plan Commission, according to the September *Blue Cross Quarterly* published by the Associated Hospital Service of Philadelphia.

Broadly, the program calls for a national Blue Cross contract; reciprocity among plans regarding service benefits (so that subscribers to any approved Blue Cross plan will receive service benefits wherever hospitalized); a uniform individual enrollment policy, and a national enrollment office.

In a letter to all Blue Cross plan directors, E. A. van Steenwyk urged the immediate submission of the proposed program to their boards of directors.

"The job can't wait," he said, "nor should we be afraid of the problems that are involved. My own experience assures me that member hospitals, trustees of plans and insurance commissioners of the various states are sympathetic with all of these objectives and will assist in achieving these goals. If Blue Cross is going to move forward to greater usefulness, agreement on a national contract, reciprocity and the enrollment of individuals must soon be reached."

It now seems to be apparent that as soon as Blue Cross plans generally can agree on these matters, a national public relations program can be launched on a broad scale. Many executives have stated that such a program would be relatively ineffective until there was a national contract, reciprocity and individual enrollment.

A tabulation by the staff of the Hospital Service Plan Commission indicates that 77 of the 80 approved Blue Cross plans have agreed to transfer and make branch office enrollment arrangements that substantially achieve the "once a member, always a member" slogan. They will (a) accept as participants people who are paid-up subscribers of other plans without applying their local enrollment limitations; (b) recognize the previous enrollment period in another plan as the basis for qualifying under any waiting period they may have, and (c) accept the employes of a branch office, even though smaller than the regular minimum group, if the home office employes are enrolled in another plan. Four of these 77 plans excluded agreement (b) but agreed to (a) and (c). Three plans do not yet agree to any of these provisions.

A proposed enabling act for Blue Cross plans and Blue Shield (medical service) plans was circulated last month by the Hospital Service Plan Commission. It is similar to the model law drafted in 1939 but includes medical care provisions for the first time. The act is to be submitted to the National Association of Insurance Commissions for approval and sponsorship.

Polio Clinic and Hospital Center Needed in Washington, Senators State

By EVA ADAMS CROSS

WASHINGTON, D. C.—Sen. Millard Tydings of Maryland predicts that his recently introduced bill to provide for the establishment of a modern, adequate and efficient hospital center in the District of Columbia will be approved by Congress.

The bill would make federal funds available for construction of a 1500 bed hospital for the joint use of Garfield and Emergency hospitals. Any of the other private hospitals of Washington would be permitted to join as participating or associate members. There would be provided also necessary parking space, appurtenances, equipment and other facilities, such as operating rooms, laundries, laboratories, x-ray machines and nurses' school and home.

The plan calls for the center to be operated on a self-sustaining and nonprofit basis. The participating hospitals would carry the full load of the operating costs. Senator Tydings has stressed the fact that Congress would not be expected to contribute anything toward annual expenses.

Senator Langer of North Dakota submitted an amendment September 8 to his earlier resolution asking for an appropriation of $10,000,000 for national study of the causes and cure of poliomyelitis. The amendment asks for $10,000,000 to be used under the direction of the surgeon general of the U. S. Public Health Service for the investigation and study of the origin, causes and means of control of both infantile paralysis and encephalitis.

Of this amount, $1,000,000 would be used for the establishment in the District of Columbia of an infantile paralysis clinic to be operated by Sister Kenny, under the general supervision of the surgeon general of the U. S. Public Health Service.

The surgeon general would consult and cooperate with the National Foundation for Infantile Paralysis in carrying out the provisions of the joint resolution.

Typhus Medal Awarded

WASHINGTON, D. C.—The United States of America Typhus Commission Medal has been awarded by order of the President to Dr. Abdel Wahed El Wakil, Egyptian minister of health, and to three British brigadiers of the Royal Army Medical Corps for the help they have given representatives of the commission in investigating typhus fever in the Middle East and southern Italy, according to an announcement of the War Department September 11. The brigadiers are John S. K. Boyd, George B. Parkinson and Rudolph W. Galloway.

Virginia Liebeler Receives Gold Medal Award for Best Article

For the first time since its establishment The MODERN HOSPITAL Gold Medal Award for an article judged to be the most helpful and significant for the advancement of hospital service was presented to a woman. Also for the first time it was presented to a person engaged in Blue Cross activities. Awards were made at the magazine's editorial board meeting in Cleveland on the evening of September 30.

Virginia Liebeler of Minneapolis received the first award for her article in the February 1944 issue entitled "How the Blue Cross Came to Rural America." In commenting on the article, Dr. A. C. Bachmeyer, chairman of the committee of award, said: "The subject is an important one which presents many problems. Mrs. Liebeler's article indicates initiative, has demonstrated its practicality and her plan has breadth of application. The quality of expression is very good."

Silver medals were awarded to Dorothy Rogers Williams for her article published in June 1944 under the title, "The Shape of Things to Come in Nursing Service," and to Robert N. Brough of Norwalk, Conn., for his two articles, "Objections Overruled" and "Another Vote for the Blue Cross," published in May and June 1944.

Mr. Brough's two articles on radiology are really two installments of what was originally one article. One of the judges commented: "This pair of articles is timely, shows evidence of some investigative work and indicates a courage too seldom observed among hospital executives."

Nineteen articles received at least one vote from the judges, who in addition to Doctor Bachmeyer are Dr. Basil C. MacLean, Dr. Robin C. Buerki and Gladys Brandt.

Mrs. Liebeler has written since she was a child. She majored in English at the University of Minnesota from which she was graduated in 1922. She worked for the Minneapolis Society of Fine Arts from 1928 to 1935 when she joined the staff of the Minnesota Hospital Service Association under E. A. van Steenwyk. After eight years there, she resigned in July 1943 and joined the Northwest Hospital Service Association in Portland, Ore.

Recently Mrs. Liebeler returned to Minnesota to rejoin her family. One of her three children is a nurse and another is now awaiting a call into the Air Corps. Mrs. Liebeler's first published novel, "You, The Jury," was released by Farrar & Rinehart on August 24 and is now in its second printing.

Mrs. Williams holds a B.A. from Wellesley College (1918), an R.N. from the Presbyterian Hospital School of Nursing, Chicago (1921) and an M.A. from Teachers College, Columbia University (1926). She was assistant director of nurses at Washington Boulevard School of Nursing, Chicago, and Washington University School of Nursing, St. Louis, and director of nurses of Barnes Hospital, St. Louis. From there she went to John Sealy College of Nursing, Galveston, Tex., from 1931 to 1935. Then for another four years she was assistant professor of nursing education at the University of Chicago. In 1939 she returned to Presbyterian Hospital as director of nurses.

Since her marriage in 1941 Mrs. Williams has lived in Cleveland and has been director of the volunteer nurse's aide corps of the American Red Cross until this year when she became the executive secretary of the Association of Collegiate Schools of Nursing.

Mr. Brough came to the United States at the age of 6 from England. For a time he was secretary to Judge Elbert H. Gary, chairman of the U. S. Steel Corporation. During World War I he was a Y.M.C.A. secretary in France with the 28th Division. On his return he entered accounting and, in 1923, became comptroller of Postgraduate Hospital, New York City.

Four years later Mr. Brough was named superintendent of what is now the East Orange General Hospital, East Orange, N. J. He became superintendent of Norwalk General Hospital in 1934 and since that time the hospital has practically doubled in size.

O.P.A. Appoints Advisers

WASHINGTON, D. C.—An advisory committee to represent the American Hospital Association on O.P.A. matters was recently appointed by the Office of Price Administration. Committee members are: Arden E. Hardgrove, chairman, Dr. Claude W. Munger, H. J. Mohler and Arthur J. Will.

Polio Cases Can Be Admitted to Wards

WASHINGTON, D. C.—Poliomyelitis cases may safely be admitted to general wards of hospitals, Dr. Betty Huse of the crippled children's service, Children's Bureau, said recently. She declared, moreover, that this recommendation in regard to hospitalization has behind it the authority of an advisory group of distinguished physicians and surgeons, working with the New York State and New York City departments of health. Doctor Huse urged immediate hospitalization when the disease is suspected so that the victim may get the expert treatment which, in many cases, can prevent crippling.

The general fear in the community, Doctor Huse explained, is responsible sometimes for a hospital's unwillingness to admit infantile paralysis cases when only ward accommodations are available. Polio cases need not be placed in separate wards, though it may be desirable to do so for ease in handling.

W.P.B. assured hospitals on September 9 of enough supplies and equipment to treat all the cases so far reported in the present epidemic and two and a half times that number if they should develop.

The Office of Civilian Requirements has acted as a clearing house through the hospital section and the chemicals, drugs and health supplies division to put hospitals in touch with sources of equipment and supplies and manufacturers in touch with materials. A supply of washing machines, held for emergency use, has been provided, and wool and sheets are readily available.

Have You a Plan for "V-E DAY"?

Plans for "V-E Day" have been made by Wesley Hospital, Chicago, as follows:

1. Each department head is to line up ahead of time certain dependable people in his department and to insist that they report to the hospital on "V-E Day" as soon as possible after the news is released.

2. Members of the office personnel and other dependable persons will be expected to report to the hospital promptly and to accept assignments in any departments that are seriously short-handed.

3. All elective surgery will be postponed for two or three days and the people ordinarily engaged in admitting these patients, in staffing the operating rooms and in other aspects of their care, will be assigned to other essential jobs in the hospital that are not being filled.

REGIONAL ORGANIZATION IN MAINE

SERVED BY LEWISTON

1—Rumford
2—Farmington
3—Skowhegan
4—Waterville
5—Augusta
6—Camden
7—Rockland
8—Damariscotta
9—Boothbay Harbor
10—Bath
11—Brunswick

SERVED BY BANGOR

A—Greenville
B—Dover-Foxcroft
C—Island Falls
D—Houlton
E—Calais
F—Lubec
G—Bar Harbor
H—Blue Hill
J—Castine
K—Belfast

AN OVER-ALL VIEW

SAMUEL PROGER, M.D.

Medical Director
Joseph H. Pratt Diagnostic Hospital
Boston

THE habit of exchanging ideas is not new to hospitals. On the other hand, hospitals until recently have almost scrupulously avoided working with one another. In this sense they have been decidedly isolationist. The days of such medical isolationism are over. The regional grouping of hospitals for the purpose of supplying better medical service is an established fact.

24 Hospitals in Program

The Maine program of regionalization with which this symposium is concerned has been made possible by the Bingham Associates Fund and functions through the New England Medical Center* in Boston, two regional centers—Central Maine General Hospital, Lewiston, and Eastern Maine General, Bangor—and 24 community hospitals.** To our knowledge this is the first such organization of hospitals. It has been functioning since July 1937, long enough to demonstrate its value and to indicate the direction of future development. Many of the details of the program, as well as the underlying principles, have been described elsewhere,[1-6] and other writers in this symposium will elaborate further from firsthand experience. My purpose is largely to discuss the place of the medical school in the program.

The entire program is fundamentally educational. As such it is only logical for it to have an educational base. It is a medical program; therefore, it needs a medical base. Ideally, then, a clinical center, such as can be organized around a medical school, is best adapted to serve as the nucleus for the program.

A single small hospital working alone can improve just so much. Real progress has been made when such a single small hospital joins with other single hospitals to form a group working together for certain mutual benefits. It has taken many years to begin to achieve this step forward. Is it too much to hope that we can look ahead to the next step which will have groups of hospitals working together for further benefits which they might not otherwise obtain? Such further benefits could best be obtained through affiliation of these groups (preferably through regional centers) with a medical school hospital center, as I believe we have demonstrated in the Bingham program.

The rôle of the medical school hospital center is vital and any regional planning should take this fact into consideration. It is not enough to feel that somehow, as the occasion may arise, a medical school might be utilized. The medical school should be made an integral part of the planning from the outset.

Regional groupings of hospitals may be of two types. There may be a more or less homogeneous group of hospitals (as to size and facilities) working with one another, or this same group of hospitals may be organized to work with a larger hospital in some regional center. The Bingham program until recently has limited itself to the latter arrangement. The Kellogg plan in Michigan is an example of the former arrangement. Both plans have certain virtues, and it may well be that a program should embody the good features of each to achieve its fullest usefulness.

Groups Are of Two Types

We may refer to the two types as the uniform grouping and the centralized grouping. The uniform grouping tends to make for a more efficient and economic utilization of hospital facilities, including technical personnel. The centralized grouping because it includes not only the grouping of smaller hospitals about a regional center but also the grouping of the regional centers about a medical school hospital center serves the purpose of providing avenues for the more rapid dissemination of advances. One grouping tends to favor more efficient utilization, the other, more rapid dissemination; these two functions can and should be complementary.

The centralized grouping aids in the improvement of those medical services requiring increasing expert-

*The New England Medical Center consists of the Boston Dispensary, the Boston Floating Hospital, the Tufts College Medical School and the Joseph H. Pratt Diagnostic Hospital.

**Smaller units affiliated with the Central Maine General Hospital are as follows: Augusta, Bath, Boothbay Harbor, Brunswick, Camden, Damariscotta, Farmington, Gardiner, Rockland, Rumford, Sanford, Skowhegan, and Waterville (Sisters' Hospital and the Thayer Hospital). The following units comprise the Eastern Maine General Hospital group: Bar Harbor, Belfast, Blue Hill, Calais, Castine, Dover-Foxcroft, Greenville, Houlton, Island Falls, Machias. (Three of these hospitals, Sanford, Gardiner and Machias, were omitted from the map shown on page 45.—Ed.)

[1]Farnsworth, G. B.: The Advancement of Rural Medicine, Bull. Acad. Med. of Cleveland (Dec.) 1937.

[2]Proger, S.: Joseph H. Pratt Diagnostic Hospital, N.E.J. Med. **220:** 771-779 (May 11) 1939.

[3]Gottlieb, J.: Bingham Hospital Extension Service, J. Maine Med. Assoc. **31:** 6, 155-158 (June) 1940.

[4]Proger, S. The Tufts Postgraduate Medical Program, N.E.J. Med. **225:** 351-358 (Sept. 4) 1941.

[5]Pratt, J. H.: The Work of the Bingham Associates Fund in Maine, J. Maine Med. Assoc. **33:** 11, 243-249 (Nov.) 1942.

[6]Proger, S.: Distribution of Medical Care: A Postgraduate Program to Fit a Pattern of Medical Practice, J.A.M.A. **124:** 823-826 (March 25) 1944.

ness. Such a graded grouping represents, as I have said elsewhere, a cross-section of hospitals spread over a wide geographic area to care for a large general medical population through organized channels of filtration. Actually, this principle already obtains in large metropolitan general hospitals. Hence, patients go from out-patient general clinics to special clinics, from general wards to special services; specimens go from resident pathologists to associate pathologists, to the chief pathologist; x-ray problems, from a resident to a chief, and so forth.

Opportunities for such automatic progression should be made available to patients in small communities as well. Channels should be left open for orderly, rapid and automatic filtration so that the patient in the most distant and isolated community has potentially and easily available the most specialized services that can be developed in the widest practicable geographic area.

No Isolation at Any Level

The isolated physician is better off when he has a hospital. The isolated hospital is better off when it works with other hospitals. The isolated group of hospitals is better off when it works with other isolated groups, and so on. There should be no arbitrary limitations leading to relative isolation at any level.

The uniform grouping should aid largely in the more efficient administrative functioning of the hospitals involved. If administrative functions become centralized, there arises the danger of centralized control. Such functions, if they operate in a uniform grouping on the other hand, cannot give rise to centralized control, since there is no centralized unit. Thus, administrative functions are not included among the hospital extension services that the Bingham program has thus far offered.

There has recently been established in Maine through the efforts of Dr. F. T. Hill, president of the Maine Hospital Association, a number of more or less uniform groups of hospitals in the state, and it is with such groups that Doctor Hill is now undertaking to set up a system of uniform accounting which is a distinctly administrative function. The administrative problems of smaller hospitals are often different from those of larger hospitals and they can best be

worked out among uniform groups of such small hospitals.

It is with this fact in mind that we are planning a one week seminar in Boston to be limited to superintendents of small hospitals and their peculiar problems; this at the instigation of Pearl Fisher, the superintendent of Thayer Hospital at Waterville.

The problem of administration and organization has been raised. In planning new programs, such as regionalization, for example, certain things should be kept in mind. A medical program should first establish a general aim. In our own case, for example, the aim is to improve the quality of medicine in smaller communities by a program of medical distribution. Then it becomes necessary to evolve a plan.

The plan should initially entail a minimum of organization and administration to avoid becoming bogged down in administrative problems, many of which are more fancied than real. With too much organization and administration there develops an unconscious tendency to mold the program to fit the administrative pattern when, ideally, the administrative pattern should develop in response to the demands of the actual functioning of the program.

Administration tends to consolidate; that is its function. Consolidation should follow and not precede experimentation. Experimentation involves by its very nature the principle of trial and error and should proceed one step at a time in such a way as to leave little room for major reversals.

Also, an experimental program, since it is charting new fields, must have flexibility. Flexibility implies freedom of action. Such freedom must not be too much hampered by arbitrary administrative controls lest the aim be lost sight of and the whole purpose defeated. Administration and organization should bring up the rear and consolidate established gains so that forward unhampered movement may be continued. There is a deceptive clarity to detailed blueprints that is dangerously alluring.

The spirit of inquiry which makes the practice of medicine vital, the spirit of humility which makes it great and the spirit of intellectual controversy which makes it so stimulating are all greatly fostered by the academic atmosphere which a medical school, better than anything else, can effectively instill into a hospital.

The uniformly high quality of medical care in teaching hospitals, that is, hospitals actively affiliated with medical schools, is largely the result of such attributes. There are, of course, hospitals not affiliated with medical schools which nevertheless have been able to create about themselves a teaching atmosphere. Such hospitals are, however, relatively few and even they would probably profit from an active affiliation with a medical school if it could be arranged.

Teaching Qualities Extended

Through Tufts and the Bingham Associates Fund we have tried to extend into even the distant and small hospitals some of the qualities that characterize a teaching hospital. This has been accomplished through a free interchange between the school center and the affiliated hospitals of practicing physicians, teachers, hospital services and patients. Some of these activities, such as teaching ward rounds, had been instituted in only a few of the hospitals before the war.

After the war it is our hope not only to extend what we have already done in this regard but to fix further the teaching character of the hospitals by a free interchange of undergraduate students and interns as well. Obviously, such plans cannot now be put into effect.

Through a system that can emanate from a medical school real clinical teaching centers might be established, not only in the regional centers but in the smaller community hospitals as well. The beginnings of what might be called an extension faculty have already been made in Lewiston through the appointment of Dr. Julius Gottlieb as instructor in pathology and bacteriology in the postgraduate division of

Tufts Medical School. Other appointments are being planned.

The regional and smaller community clinical centers, since they would introduce considerable numbers of students and interns into the areas concerned, might do much to maintain an adequate flow of physicians into those areas.

One of the chief virtues of the Bingham Associates Fund program is that it has functioned primarily through the practicing physician. Originally, practitioners worked together in an educational program. (The most elaborate and the most ideally conceived plans for the distribution of medical care will disintegrate if doctors will not work together.) As a result, certain problems were created which made it necessary to provide increasingly satisfactory hospital facilities so that the benefits of the clinical associations could be realized.

The dissemination of medical advances should begin with the clinician; he must first be made aware of these advances before they can be instituted. There would be no point in introducing assay methods for hormones into a hospital laboratory until someone on the staff knew what use to make of these assays. The practicing physician must be kept continuously informed; then he must be given the opportunities to put this information to good use. Again, the basic importance of an educational program intrudes itself and it is the medical school which can probably best serve as the catalyst for such a program.

There are many and good reasons why a medical school should be integrated into a regionalization of hospitals; there seems no good reason why it should not.

AS A TRUSTEE SEES IT

SAMUEL STEWART

President
Central Maine General Hospital
Lewiston

HOSPITAL trustees are responsible not only for the business management of their institution, but for the ultimate care of the patients through the medical staff. Their interests must, therefore, encompass the financial problems, the structural and physical needs of the institution and the qualifications of the staff members upon whom rests responsibility of the care of the sick. Educational factors that may advance the skill of its staff or any of its technical and nursing personnel are of paramount importance to a board of trustees.

Dedication of the new west wing of Central Maine General Hospital, Lewiston, on July 24, 1931, provided facilities not only for more than doubling the patient occupancy but also for establishing an extensive program of postgraduate studies. This is in addition to the teaching clinics which have been successfully carried on since 1929, first under the direction of Dr. Soma Weiss of Harvard Medical School and later under an advisory committee composed of Dr. Reginald Fitz, Dr. Chester Keefer and Dr. Samuel Proger, respectively representing teaching interests of Harvard, Boston University and Tufts Medical School.

A most important obligation of a hospital is centered about its value as an instrument of advancing medical education. In the small hospitals, staff meetings, conferences, ward walks and consultations serve this purpose. In the large medical centers these are intensified and, in addition, planned postgraduate courses are conducted.

Central Maine General Hospital occupies an intermediate position between the small and university teaching hospital in size and potentialities as a teaching center. This is true of numerous similar institutions throughout the country. Maximum utilization of the teaching facilities of these institutions is now becoming more important than ever, particularly with the approach of the postwar era with the inevitable and greater need for additional teaching institutions.

Central Maine General Hospital in cooperation with the Bingham Associates Fund became interested in the smaller hospitals of this section, believing that much could be done to make them better hospitals and also to make Central Maine a better institution. Appraisals and methods had to be established before progress could be made. The instruments and standards of measurements vary in different hospitals, but they all follow a basic pattern. They must meet certain minimum requirements of the agencies that establish their rating.

A number of basic procedures are involved in the operation of a hospital. It was not economically possible for any single small hospital fully to carry out these basic procedures in a manner in keeping with accepted standards. A pooling of resources by some cooperative effort, such as that fashioned by the Bingham Extension Service, makes possible the attainment of standards and the rendering of services consonant with advanced medical practices.

To bring about a condition wherein a new way could be found and utilized, it was necessary to have the active interest of some organized group keenly interested in the promotion of medicine, hospital procedures, advancement of the professional and technical staff and in the management itself.

Speaking at the annual meeting of the New England Hospital Assembly, March 1939, Doctor Proger briefly explained the Bingham Hospital Extension Service as follows:

"The plan of the Bingham Associates Fund is broadly designed to attempt to diffuse into small communities the medical advantages of a metropolitan center by direct and indirect contacts between these elements arranged on a permanent basis. It is intended that the small communities maintain their opportunities for independent work but that this work be integrated with that of larger centers.

"Any project or planned program must be founded on sound basic principles by which all who participate shall equally profit thereby. It must have economic value and be a progressive and orderly program of education and constructive and scientific treatment of the patient care problem. The Bingham Associates Fund, Central Maine General Hospital, Joseph H. Pratt Diagnostic Hospital and Tufts Medical School found the ways and means whereby such a program could be realized.

"In the eight years since the Bingham Hospital Extension Service had its beginning in the Central Maine General Hospital, much progress has been made, and not only have the benefits that have accrued been effective in the smaller affiliated hospitals but Central Maine has benefited as well.

Entire Program Is Educational

"The Bingham Hospital Extension Service acts to decentralize hospital services somewhat but, at the same time, keeps smaller hospitals in closer affiliation for consultation where diagnosis is not clear or where treatment facilities are not available. The central hospital is encouraged to better its own diagnostic facilities, and the fact that it is a diagnostic center is ever kept in mind. The entire program must be a unified educational process which must, of course, mean a cooperative one."

Facilities for diagnosis have been brought about in the Central Maine group. The affiliated hospitals have established laboratories staffed by medical technicians where routine examinations are performed by the resident technician and tissues are sent to the pathologist of Central Maine General Hospital. The technicians are frequently supplied through the hospital's school of medical technology with supervision and consulting service in the hands of its pathologist. Roentgenologists make periodical visits to these hospitals. They are also available for consultation and interpretation of the films that may be sent to them.

The services of a cardiologist are available for interpretation of the electrocardiograms and also for consultations. Scholarships, fellowships and refresher courses have been available to the physicians and technicians.

Intern education at Central Maine has been supplemented through bimonthly visits of prominent specialists in the field of medicine. It has been an important factor in graduate education. Cases are worked up by the interns and presented by them to the visiting physician and discussed by the staff and guest physicians.

The school of medical technology is affiliated with the school of medical technology recently established at Colby College, Waterville, Me. With the added facilities of Joseph H. Pratt Diagnostic Hospital and Tufts Medical School, there is a cooperative effort to train medical technicians in the best possible manner and to the advantage of the students and to the field they plan to enter.

Through the kindly interest of the Bingham Associates Fund and friends, the Gerrish Memorial Medical Library was established seven years ago. This library with its large number of medical books, periodicals and reprints is available to the members of the Maine Medical Association and has been a potent factor as a means of education. The annual anniversary observance is an important event in the hospital calendar and the Gerrish lecturers have been outstanding leaders in the medical and educational fields.

The medical staff and technical force have been given opportunities for continuing education which has added much to the value of the services they render. Likewise, postgraduate study made available to the medical and technical forces of the affiliated hospitals has given to them opportunities for advanced study similar to those that are available to the central hospitals. Thus, all involved are better prepared to utilize the facilities available to them and to render better service to the sick.

Postwar Services to Be Broader

The war has interrupted education in all its branches. Postwar services will, however, be upon a broader base than ever before and our hospitals and medical schools must be prepared to meet the demands for increased postgraduate study.

The educational programs of the Bingham Hospital Extension Service cannot function to full advantage because of the absence of so many physicians. When conditions revert to normal in the postwar era, it is expected that the Bingham program will bring about closer cooperation among the smaller hospitals themselves, as well as with the central hospitals and the forces that have made their betterment possible.

With a well-equipped hospital, with a cooperative board of trustees and medical staff, with opportunities for postgraduate study, with a central hospital available and with the Bingham Associates Fund there have come to the small hospitals and general practitioners of two groups in Maine opportunities that otherwise would not be available. By cooperative effort benefits for the sick prevail in these small hospitals and the communities they serve.

Elevation of medical standards in one institution is of indirect benefit to its neighboring institutions. Trustees of any hospital should look with favor towards the advancement of its neighboring hospitals. The well-being of any community is of equal importance to its neighbor. This attitude of neighborly cooperation is in line with the national plan, albeit on a smaller scale than that fostered by the United States Public Health Service.

In brief, cooperative spirit among neighboring hospitals is of ultimate benefit to each of the hospitals and the communities they serve.

Lucille Peirce Kelley Building, erected in 1939, is the newest of a group of nine buildings composing Eastern Maine General Hospital.

From the Administrators' Point of View

PARENT HOSPITAL

ALLAN CRAIG, M.D.
Medical Director
Eastern Maine General Hospital
Bangor

THE crest and seal of the Maine Hospital Association bears these words: "Together for others." The extension services that are being carried on in this state by two of its largest hospitals are an example of the practical application of that slogan. There can be no greater satisfaction to the institutional mind than that to be found in the realization of helpfulness to others who need and appreciate that assistance.

In the state of Maine distances from place to place are great—much greater than most people outside the state realize—and there are many districts that are sparsely populated. Obviously, not all the sick and injured in the state can be treated in the few large and well-equipped hospitals. In fact, the majority of the hospitals in Maine are small institutions, with 50 beds or less, but they serve a necessary function in their communities and surrounding districts. And the patients in these small hospitals have a just right to expect the best scientific care that it is possible to give them.

The large departmentalized hospital, on the other hand, fully equipped and more adequately staffed with medical men especially trained and experienced in certain fields of work, can and should definitely assist the small institutions. The parent, or larger, hospital can provide what the smaller institution lacks. In unity between the large institution and the small is to be found both strength and efficiency of service.

We in the parent hospital feel that we are contributing to this objective when we can make better laboratory, x-ray and other specialized facilities available for the doctors and their patients in the small hospitals. One definite objective of all progressive hospitals should be the greatest service to the greatest number of those who need it.

The influence and services of any institution should extend far beyond its four walls and its immediate environment. In the parent hospitals in Maine, we are convinced of such obligation on our part and are putting these obligations into practical application.

The periodic visits by the heads of our departments of radiology and pathology to the participating hospitals provide for the heads of these departments first-hand knowledge of working facilities in these small institutions and we believe that these visits are an added stimulus toward better work.

Many patients eventually come to the large hospital centers from the small institutions for special treatment and study. By having available laboratory and x-ray facilities in the tributary hospital, these patients are more adequately prepared before admission to the parent institution. Their investigation and treatment in the large hospital become in a sense a continuation of work already accomplished and copies of their laboratory and x-ray findings to date are already on file.

It must be kept in mind, however, that these are only the foundation for further investigation. No good hospital and no careful physician are justified in accepting at full face value the results of laboratory and x-ray examinations that might be out of date or with which they have not had personal contact. This is especially true in questionable cases or those that require surgical procedures.

Reliable comparisons of findings, however, are always of great value and are never to be overlooked. Their value is enhanced somewhat by the fact that the procedures of investigation are carried out in the same laboratory by the same staff of technicians.

The periodic conferences held, in normal times, at two week intervals in the parent hospital are extremely valuable. At these conferences members of the medical staffs from the outlying institutions assemble to dis-

cuss their cases with the radiologist and pathologist. These group discussions are informal and compare favorably with any clinical conferences I have known.

The general practitioner in the small community, who, up to a certain point, has to be his own radiologist and his own pathologist, brings to us many a gem of practical experience and exhibits judgment and self-reliance which one fears may not be too well cultivated in some of our newer graduates or in men who are accustomed to more complete scientific surroundings and ready consultation services.

One cannot discuss the extension of scientific services in Maine without paying tribute to the Bingham Associates, whose constant interest, vision and financial support have made this work possible.

As helpfulness always stimulates the helper, so does our extension work build up and strengthen the esprit de corps of each participating department of the parent hospital. Each institution is the better for the fact that we are participating in such a valuable effort.

In the days to come, when, we trust, the pressure of war-time conditions will be relieved in our parent hospitals, and when medical men now in the armed services will be back in their home communities, we hope to broaden our extension work to fields not now covered and to extend our relationship even more firmly and more serviceably with the smaller hospitals.

OUTPOST HOSPITAL

HELEN GOODWIN, R.N.

Superintendent, Rumford Community Hospital, Rumford, Me.

TODAY, the directors and administrator of a small community or rural hospital have to recognize the fact that there is more to serving patients than the erection of a modern building, the recruitment of a staff of well-trained and progressive physicians and surgeons and the employment of a competent nursing staff.

Adequate facilities must be provided, particularly in the laboratory, x-ray and dietetic departments. First, the laboratory should be equipped to handle diagnostic procedures, basal metabolism rate determinations and electro-cardiography, and the technician should be capable of making blood chemistry and clinical pathology tests. In addition, some means must be provided for making tissue examinations and pathological diagnoses. Second, x-ray examination requires a well-equipped department with a proficient technician and the services of a radiologist. Third, for proper diet therapy, there should be a well-trained dietitian who, in addition to managing the dietary department, is capable of teaching student nurses, when there is a school of nursing.

For those small hospitals in Maine to which the expense of such facilities would be burdensome, and in some cases prohibitive, help has been made available through the Bingham Associates Fund for the Advancement of Rural Medicine.

Our hospital has no local pathologist, as pathology is a highly specialized subject, and it is impractical for a physician to practice it on a part-time basis. Hence, we routinely send all tissue specimens to the central hospital. In our area, this is the Central Maine General Hospital in Lewiston, where enough material accumulates to occupy a full-time pathologist, who, in turn, sends a written report back or telephones us.

Pathologist Aids Local Staff

We have a further consultation service in that he may send any questionable specimens to the head of the pathology department at Tufts College in Boston. The local practitioner may call upon the central pathologist for postmortem examinations. While we do not avail ourselves in all such examinations, the tissues are examined and the final diagnosis is made by the pathologist.

We are too far away to consult the central laboratory on new technics, and so, through the Bingham Associates, an itinerant technician is supplied and a scholarship is granted for our technician to have courses in chemistry and bacteriology or for specific instruction in new procedures, such as rh factor determination. This course is given at the Joseph H. Pratt Diagnostic Hospital. Basal metabolism determinations are done at our institution. Also electrocardiographic tracings are taken, duplicates of which are sent to the central hospital for checking and independent diagnosis.

From the time of the opening of the hospital in 1926 to July 1943, the expense of the services of the radiologist was assumed by the Bingham Associates Fund, but we now pay for this service. Dr. Roland Clapp, the radiologist of Central Maine General Hospital, comes once a week to read films taken from the time of his last visit. At this same time the gastro-intestinal series with fluoroscopy is scheduled for him to do. We have further benefit in that the radiologist attends the seminars at the Massachusetts General Hospital in Boston, and he may take with him for consultation any films he considers questionable.

Dietetics has found a real place in modern medical practice, and the fund has helped us materially by the grant of a scholarship to our dietitian for an annual one month course in hospital dietetics at either Joseph H. Pratt Diagnostic Hospital (hospital dietetics) or the Boston Dispensary (food clinic training).

THE COUNTRY DOCTOR BENEFITS

A. J. FULLER, M.D.
Pemaquid, Me.

Between the time this article was prepared and its publication the editors received the sad news of Doctor Fuller's sudden death. Doctor Fuller was well known throughout his section of the state for his tireless efforts to promote better health practices in rural Maine

THROUGH funds established by the Bingham Associates much help has been rendered the country doctor in Maine by enabling him to take courses of study in subjects in which he finds himself particularly weak. These courses are planned to give help to men who are not familiar with good modern medicine. They reveal the importance of certain facts in diagnosis and treatment and stimulate a desire on the part of the practitioner to be able to ascertain and use these facts.

Any reputable physician in the state can thus broaden his general knowledge, prepare himself for a specialty or improve his technic in that specialty. In other words, he can obtain anything that he may need to meet the standards of satisfactory medicine.

Complacency Vanishes

At the time that I was offered a fellowship for study in Boston I, like many other country doctors, was too busy to realize the progress that medicine had made in recent years. I was inclined to be a bit complacent even over the service I was rendering. It was an eye-opener to visit the Boston Dispensary and to realize the need for continued study and a regular check-up on one's personal views through postgraduate work in conjunction with men conducting research along those lines. It was illuminating to behold at first hand the manner in which cases were examined by eminent physicians, the use of laboratory facilities and the coordination of both in the diagnoses reached.

During the years, I have taken 11 courses at the medical center, every one of which was urgently needed to keep me abreast of current progress. These would have been impossible had it been necessary for me to meet personally the full tuition and expenses. These courses were in primary medicine. Then, three times I took one or more advanced courses, one in hematology, another in cardiology, two in electrocardiography and one in advanced electrocardiography. More recently, I completed a course in anesthesiology in order to familiarize myself with intravenous anesthesias.

The need for laboratory aids in the country was apparent. In consequence, I started one in a small way at my office. Laboratory facilities sufficient to care for the regular needs of the locality with a trained technician in charge are available, of course, in the hospitals connected with the Bingham Plan. There is a consulting service, too, in electrocardiography and roentgenological problems, first with some of the larger local hospitals and then, if necessary, with Boston.

Sometimes, however, a doctor may wish to know things about a patient and for various reasons (I am 10 miles from a hospital and examinations there may be costly) be unable to obtain them through the hospital services. His private laboratory can adequately fulfill this need.

Any intelligent girl can be trained through the help of the Boston center (at the doctor's expense) to do what is needed by him. This laboratory obviously should contain only such equipment as is used regularly by the doctor and needed in his type of practice.

Until I took the postgraduate work given by the Bingham Associates, this need was not appreciated by me and is not appreciated, I suspect, by other country doctors, but as the advantages became so apparent, more equipment was added until my own laboratory is fairly complete and of considerable aid to the community.

Such a laboratory may not be needed if hospital facilities are easily available. The point is that any doctor who avails himself of the postgraduate work will learn so much about the various tests used that he can start and use a laboratory and get valuable information and satisfaction out of the feeling that he is doing his best to improve his work and, in consequence, improve the general quality of rural medicine.

Whole Object Is to Help Doctors

It is possible that more men do not avail themselves of these educational opportunities because they feel that there must be some string attached. They can't believe they can get something so valuable for nothing. After one course, however, they realize that the whole object of the Bingham Associates is to help them help themselves to a more complete understanding of their profession and its problems.

Here are some of the advantages the doctor practicing in Maine can enjoy through such a plan as sponsored by Bingham Associates. As a member of the staff of a small hospital I have these advantages:

1. Hospital technician service is provided with a consulting service for unusual cases.

2. Pathological reports are made on all specimens taken at operations.

3. Necropsies are done by Fund pathologist gratis if funds are not available or the cause of death is not clear.

4. Seminars in radiology or electrocardiography are conducted by trained men. These are of great advantage to the small hospitals where the staff men may not be sufficiently adept at analyzing all the unusual or rare films or tracings.

5. Prior to the war meetings were held every two weeks and these physicians were expected to attend. There their own problems were viewed and discussed.

6. If several cases of the same kind, that is heart, lung and internal medicine, can be brought together a specialist will be sent to examine them if no local man is available.

Diagnoses Made at Pratt Hospital

Another service is the sending of diagnostic problems to the Pratt Hospital at a price suited to the patient, or as a charity case. There, such patients receive adequate examination by the staff or, if occasion requires, by the best and most noted doctors available anywhere, with laboratory work and x-ray investigation sufficient to make a diagnosis. Following the examination they are returned to the local doctor with a complete résumé of the findings and definitely outlined suggestions as to treatment. This service is of great value in rare or peculiar cases in which the doctor cannot satisfactorily make the diagnosis and might be vague about the approved treatment.

Speakers of eminence in their respective lines are furnished the county medical societies. These men are not necessarily connected with the foundation and the choice of lecturer or subjects is the one desired by the society.

All of these benefits do not include the willingness, even eagerness, shown by all members of the foundation teaching staff to help anyone at any time with any question, spending hours outside of their regular duties to clear up the problem so completely that in the future it will not be a problem but something familiar. This assistance can, and usually will, change an ordinary run-of-the-mill doctor into one who knows and practices, within his limits, good modern medicine.

ACCOMPLISHMENTS IN X-RAY

FORREST B. AMES, M.D.
Roentgenologist
Eastern Maine General Hospital, Bangor

ON JULY 1, 1939, an experiment in x-ray extension work was started at Eastern Maine General Hospital, Bangor, sponsored by directors of the Bingham Fund. Methods of procedure have changed from time to time but the work is no longer experimental, having proved the soundness of the original fundamental purposes.

The use of x-ray as a diagnostic procedure in the practice of medicine has spread rapidly during the past years. Easily operated and fairly inexpensive x-ray equipment has been widely distributed by manufacturers. General practitioners have been induced to add this new modality to their office equipment. Printed technics have been supplied and everything but the most important item in roentgenology is handed over with delivery of the machines. This refers, of course, to interpretive technic: the ability to translate the black and white shadows on an x-ray film into terms of disease or health of the various parts of the human body under study.

Small hospitals, some geographically far distant from large medical centers, have joined the medical procession and installed x-ray equipment, large or small, according to the financial resources of the institution.

Usually, in the small institutions, some member of the staff, with a leaning toward newer methods of diagnosis, has evidenced interest in x-ray service and has given time from other medical duties to supervise the work. Thrown back on limited material and forced to work alone, progress in diagnostic efficiency has necessarily been slow. And patients unable to travel to large medical centers through lack of financial means, or because of the nature of their illness, have been studied with inadequate equipment and professional experience in diagnosis.

This is no reflection on any institution or physician. Roentgenology is a recognized specialty in the practice of medicine. Certification by the American Board of Radiology is given only to those physicians who make a specialty of x-ray service and who have given years to detailed training. Obviously, such a specialist can be found only in hospitals in which the volume of x-ray work is large enough to return fair professional remuneration. Obviously, too, the smaller institutions can not afford to retain the undivided services of such a specialist.

Few Personal Contacts Made

For many years some type of extension work had been considered for the small hospitals in eastern Maine. The sort of work contemplated was based on a professional consultation background and the idea did not lend itself to ready extension. In one institution, Mount Desert Island Hospital, Bar Harbor, the idea was put into effect a few years ago. All films were sent to the roentgenologist at Eastern Maine General Hospital twice a week, together with detailed clinical histories. Return was made in writing and sometimes by telephone in more urgent cases. At times, personal professional contacts were made but, on the whole, few visits were made to the hospitals.

When it became known that directors of the Bingham Fund earnestly

Place	Hospital	Miles From Bangor	Beds
Bar Harbor	Mount Desert Island	48	58
Belfast	Waldo County General	35	38
Blue Hill	Blue Hill Memorial	41	25
Castine	Castine Community	38	12
Dover-Foxcroft	Mayo Memorial	39	16
Greenville	Charles A. Dean	75	23

desired to sponsor trained assistance to small hospitals, their plans found ready acceptance and an initial group of hospitals formed the Bingham Associates for eastern and northern Maine.

The first group comprised the hospitals listed above.

The original plans were for the roentgenologists at Eastern Maine General Hospital to make weekly visits to each of the institutions, study all the x-ray films and render written diagnoses, assist the technicians in practical details of radiographic and darkroom technic and consult with members of the staff concerning differential diagnosis on the patients whose x-ray films were under consideration.

The geographical distribution was such that these visits could be made in four afternoons, two for each of the roentgenologists.

On July 1, 1939, a schedule of weekly visitations started and these continued throughout the summer and fall. As the more severe weather of the late fall and winter slowed the visits to the outlying hospitals, much thought was given to some other means by which contacts could be maintained, diagnostic facilities made available and help given to those key men who were carrying the responsibilities of the x-ray departments in these various institutions.

The simplest solution appeared to be a complete reversal of the original plan. Instead of having the roentgenologists go to the outlying institutions, it was decided to have the hospitals bring their diagnostic work to Eastern Maine General for studies and conference.

The conference idea met with the approval of the directors of the Bingham Fund and plans were made to expand the group of associates. And so during the first six months of 1940 the institutions shown at the bottom of the page participated.

The plan as outlined and put into effect called for a conference at Eastern Maine General Hospital every two weeks. To this conference some member of the staff of each hospital in the affiliated group was invited to come and bring with him all x-ray films taken in the interval between meetings. With clinical histories also supplied, the films were read and any discussion that was considered necessary was carried on.

One difficulty that developed immediately was that the number of films that could be read and discussed in one session was limited. Partially to offset this difficulty it was requested that films be sent in during the interval week so that they might be studied and only a few were set aside for discussion on conference day. Films sent in by mail were still received and many telephone consultations were held and diagnoses were quickly rendered.

The conference system met with approval. During each of the fiscal years 1940-41 and 1941-42, 24 biweekly meetings were held. Physician attendance averaged about three, scattered among the various hospitals in the group. Discussions were informal and free and much helpful medical opinion was offered.

Then came the war. Key men in the small hospitals entered the armed services. The senior roentgenologist was left alone at Eastern Maine General Hospital. The x-ray conferences were discontinued. However, consultation service on films mailed in to Bangor has been continued in considerable volume, with somewhat more use of the telephone for discussion of cases.

In order to improve the technical work in the small hospitals, a course in x-ray technic was started in October 1941. A full-time registered technician gave daily instruction for a period of six months to groups of three students. Graduates of this course have been favorably placed throughout the state.

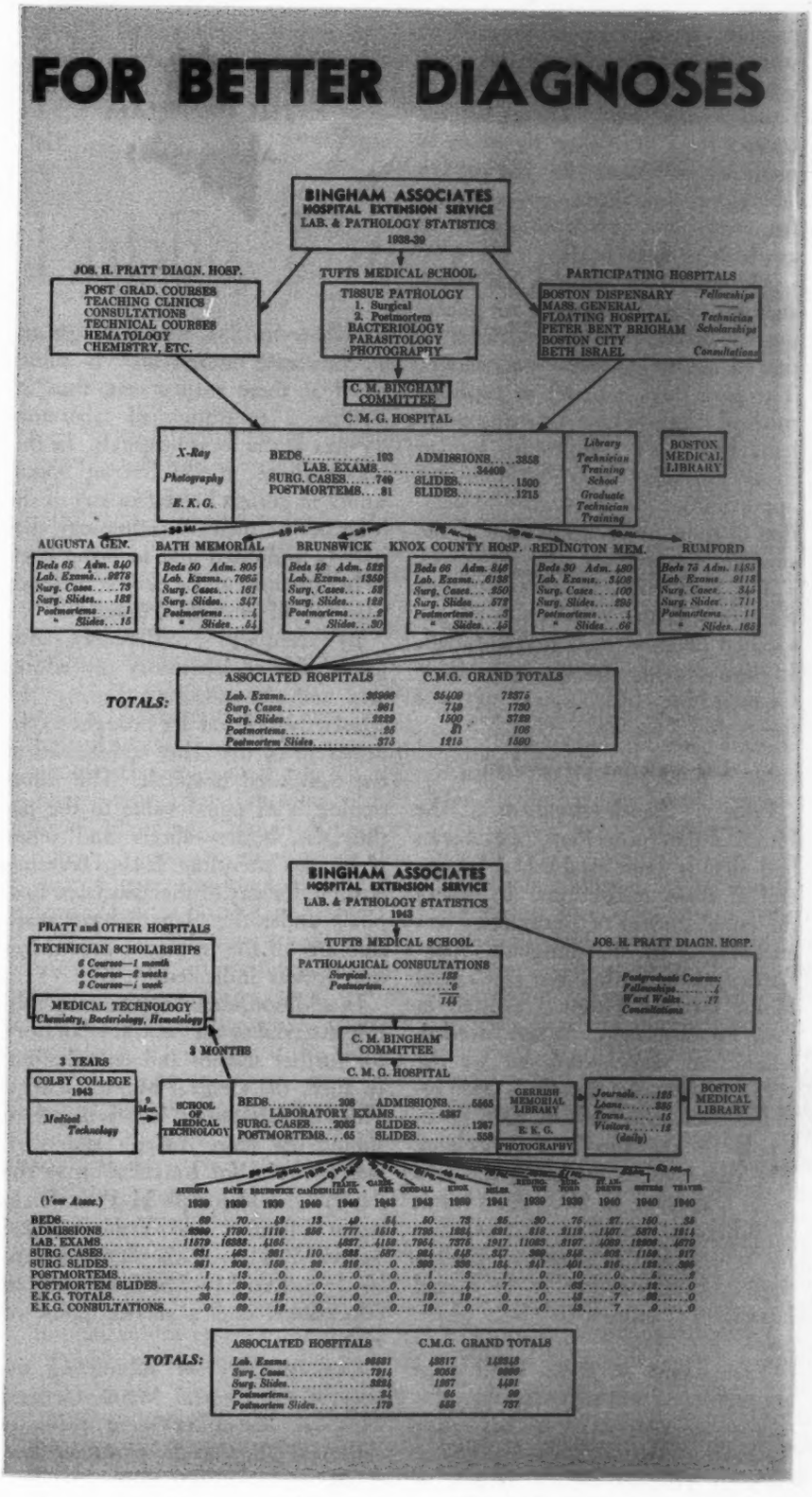
Other aspects of the Bingham Fund work included one month postgraduate courses for the x-ray technicians from Eastern Maine General Hospital in the department of roentgenology at Pratt Diagnostic Hospital, Boston. Also, the Bingham Fund subsidized trips by the roentgenologists to the x-ray conferences at Massachusetts General Hospital in Boston.

Those of us who have grown with this work believe it has proved its worth. We plan to continue the conferences as soon as conditions warrant and to make more trips to the associated hospitals as soon as professional personnel is available. We hope to improve the technical quality of x-ray films as more technicians can be trained and placed in the small hospitals. And we hope to build a professional cooperative diagnostic group that will, of necessity, improve the medical practice of roentgenology in the hospitals of eastern and northern Maine.

Place	Hospital	Miles	Beds
Bar Harbor	Mount Desert Island	48	58
Belfast	Waldo County General	35	38
Blue Hill	Blue Hill Memorial	41	25
Calais	Calais	144	56
Castine	Castine Community	38	12
Dover-Foxcroft	Mayo Memorial	39	16
Greenville	Charles A. Dean	75	23
Houlton	Aroostook General	117	40
Island Falls	Milliken Memorial	101	15
Lubec	Lubec Community	112	14
Machias	Washington County Community	85	18

JULIUS GOTTLIEB, M.D.
Pathologist
Central Maine General Hospital
Lewiston

FOR BETTER DIAGNOSES



WITH each new development and discovery of medicine in either diagnosis or treatment, it becomes the responsibility of hospitals and physicians to apply the values of such advances to the welfare of patients. Ironically, it might be stated that with each additional potential medical boon to mankind, the problems become more complex and difficult for those who have assumed the responsibility of the care of the patient. This paradox arises from the fact that medical care is intricately interwoven with other large socio-economic and educational aspects.

A new development in the diagnosis or the treatment of any disease is of no comfort or value to a patient who cannot be the recipient of its benefits. The existence of a serological test for syphilis is of no value to a patient unless such a test is available to him, nor is the discovery of penicillin of any value to a patient unless that medication can be intelligently applied to that patient.

Medical progress has in many instances outstripped the economic ability of a large segment of the population to obtain full benefit from these advances. This is particularly true in sparsely settled communities and in smaller hospitals where economic levels cannot adequately support the cost of new and advanced diagnostic methods and therapeutic facilities. At the same time, illnesses in the smaller communities are as complex and diversified as those of the larger, requiring equal professional skill, experience and laboratory aids. The diagnosis of bacterial endocarditis and the isolation of its etiological bacteria require skill and technic in a small community equal to those of the large university hospital center.

Through educational, diagnostic and therapeutic advancements, the Bingham Hospital Extension Plan aims to provide for members of small communities a quality and type of medicine approximating that of the large centers.

The extension work in pathology and general laboratory procedures represents specific divisions of the larger plan. This phase of the Bingham Associates' interests may be considered the third step in a general plan for the advancement of rural medicine in Maine. The other two are fellowship grants to practicing physicians in Maine for postgraduate study, and the developing of diagnostic facilities at the New England Medical Center.

Each of the three phases, although representing an integral unit in itself, is closely interwoven and correlated with the other activities and they are not designed to be dissociated from one another either in theory or in

practice. Each phase is designed to stimulate and complement the other —from both a service and an educational point of view. Thus, graduate courses for a practicing physician in medicine stimulate an interest in laboratory procedures, opportunities for study and advancement being available in both fields.

Although opportunities for assistance in medical diagnoses are generously offered, the basic concept is that of furthering medical education. The plan does not aim to facilitate medical diagnoses by removing problems from any community but to make available better facilities and opportunities for the study and solution of these problems in each of the smaller communities.

The plan embraces the creation of a regional center with which are associated neighboring small hospitals. In our district, the Central Maine General Hospital laboratory serves as the regional center.

Laboratories Established

Prior to the development of the Hospital Extension Plan, laboratories had already been established in several of these institutions. In others the establishment of laboratories was encouraged by the Bingham Associates and the pathologist of Central Maine General Hospital assisted in their establishment. Where needed, technicians were employed by the various associated hospitals and remuneration was met in part or in whole by the Bingham Associates. The first step in initiating the program was taken in 1937. As a result of Bingham grants, it was possible for several of the associated institutions either to create or to extend laboratory facilities to their physicians.

Technicians at these institutions are privileged and encouraged to participate in conferences on laboratory methods conducted at Central Maine General Hospital. Each technician is granted an annual scholarship to spend one month at any of the hospital laboratories in Boston or at Central Maine General Hospital. Scholarships are also awarded to the various technicians during their study in advanced courses.

Special effort has been made at the New England Medical Center laboratories to meet the educational needs of the various technicians. During their absence from their home hospitals a technician, who is designated as "itinerant technician," is substituted at these institutions, thus affording a continuity of laboratory services at the local hospitals. In this way each technician has an opportunity to perfect herself in any of the branches of medical technology that may be indicated and to bring back to her institution the newest methods used to aid in clinical diagnosis.

By frequent conferences, the knowledge of laboratory procedures and technics acquired during the scholarship period are brought to the attention of the other technicians at the associated hospitals. The information is of equal value to the pathologist, house officers and other physicians attending. It thus becomes possible for any of the associated hospitals under the plan to have available any of the technical procedures that appear indicated.

In addition, each hospital may submit material to the central laboratory for further studies and consultation. In turn, the Central Maine General Hospital laboratory is privileged to submit the more difficult and intricate material for consultation to the laboratories of Joseph H. Pratt Diagnostic Hospital and Tufts Medical School, Boston. This plan has definitely proved its value from both an educational and a service point of view.

Opportunities for submitting tissues to the Central Maine General Hospital laboratory were formally offered to the various associated hospitals in July 1938, thus extending the services already in practice. Surgical tissues and postmortem material are routinely submitted to the Central Maine General Hospital laboratory for preparation and diagnosis. Tissues so submitted are reported to the interested physician as promptly as are those prepared for physicians at the Central Maine General Hospital laboratory.

A well-trained tissue technician is provided for the preparation of microscopic sections for all the associated hospitals. All tissues are examined and described grossly and microscopically and diagnosed by the pathologist of Central Maine General Hospital and reports are mailed, or phoned when indicated, to the various associated hospitals. All slides are filed serially and reviewed with the interested physician upon request. The central pathologist may be called for frozen sections and postmortem examinations at these institutions.

This plan has now been in operation for seven years, beginning with six associated hospitals in central Maine. All other rural hospitals in this area gradually accepted the plan so that at the present writing the central Maine group includes 14 associated hospitals with the Central Maine General Hospital serving as regional center.

In the accompanying charts, under the caption of Bingham Associates Hospital Extension Service, the general structure of the plan is indicated in tabular form, showing the relationship of the various associated hospitals with the regional hospital at Lewiston, as well as the relationship of the regional hospital to Tufts Medical School, Pratt Diagnostic Hospital and other participating consulting institutions. Also included in these charts are the statistical data for 1938-39 and 1943.

Charts Show Growth of Plan

The charts indicate the distance to each of the various associated hospitals from the regional center, the year of association and the growth in laboratory services in the intervening years. A review of these charts shows the number of consultations, as well as the volume of surgical and pathological material submitted to the regional hospital in Lewiston, and in the 1943 chart is shown the beginning of the development of a school for medical technologists in association with Colby College and Pratt Diagnostic Hospital. Also indicated in this chart are the Gerrish Memorial Library and its relationship with Central Maine General Hospital and the Boston Medical Library.

The usefulness of the plan is indicated by the rapid growth in the number of associated hospitals and the number, extent and types of services rendered to each of the institutions.

Public *Education leads to* Public *Understanding*

IRENE F. McCABE

Assistant Executive Secretary, Hospital Council of St. Louis

FOR the last three years the Hospital Council of St. Louis has devoted the greater part of its efforts toward increased public understanding of hospitals, hospital services and hospital problems. Much has been accomplished but much remains to be done.

Active leadership on the part of H. J. Mohler, who has served the council as president during these years, and Ray F. McCarthy, executive secretary of the council and director of the St. Louis Blue Cross, has resulted in public acceptance of the council as the source of hospital information.

It is not with undue modesty that attention is called to the fact that in the last two years St. Louis has twice won the national award for originality and effectiveness of its public relations program.

Strive to Win Award

The establishment in 1943 of the hospital council's annual community service award for the greatest contribution to hospitals, by either an individual or a group, has proved in just a short period of time to be an honor toward which all community groups strive. This award was first presented to the Rotary Club of St. Louis for the establishment of the Rotary Nurse Foundation and the recruiting and financing of student nurses for metropolitan hospitals before the U. S. Cadet Nurse Corps was formed. The Rotary program received national acclaim and has been copied and enlarged upon by clubs throughout the country.

A permanent public relations advisory committee has been established during the past months. This committee consists of Arthur Casey, program director, Station KMOX (Columbia); Harry Wohl, news editor, *Star-Times;* Carl S. Robinson, publicity director, St. Louis Public Service Company, and H. F. Rector, advertising manager, Missouri Pacific Lines. Florence King, administrator, Jewish Hospital, serves as the hospital representative.

The committee was formed so that the hospitals of metropolitan St. Louis might benefit by the advice and counsel of outstanding men in their fields in anticipating unfavorable reaction and in proper interpretation of hospitals to the public.

Prior to National Hospital Day this year, the committee was expanded temporarily to include representatives of all organizations and agencies whose experience might be helpful. A dinner meeting early in April was attended by the superintendent of education of St. Louis high schools; heads of all nursing schools; chairman of the Red Cross nurse's aide corps; director of the Social Planning Council Volunteer Bureau; publicity director of the War Chest; president of the St. Louis Medical Society, and others.

Washington University School of Nursing had just received the first cadet nurse uniforms to reach St. Louis and two attractive students modeled the uniforms at this dinner. The students stole the show and dramatized the fact that here was a package, to quote Lucile Petry, that was both attractive and saleable.

It was agreed that our publicity campaign should be threefold: to recruit cadet nurses and high school girls as pledges; to recruit Red Cross nurse's aides, and to recruit other hospital volunteers.

Publicity was built around two main events: the presentation of the annual community service award to the Red Cross nurse's aide corps at the St. Louis Medical Society, and the mass induction ceremony for 860 cadet nurses on the plaza of the World War Memorial.

Newspaper and radio space during the six weeks' period used for National Hospital Day was amazing. Feature stories and editorials appeared in all three dailies and the Sunday rotogravure section of the *Post-Dispatch* carried a full page on the life of a cadet nurse.

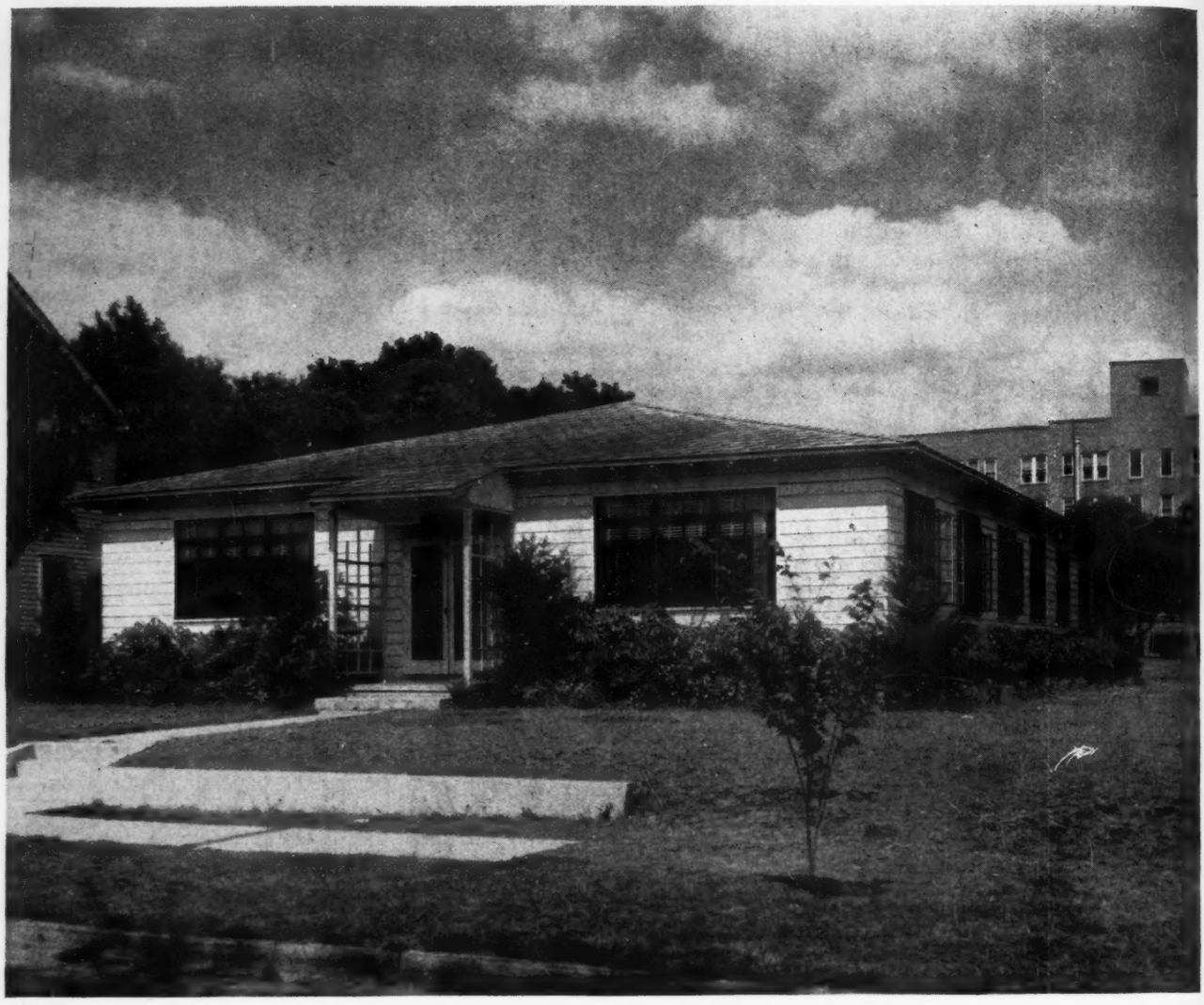
To show our appreciation and also to give hospital administrators an opportunity to get acquainted with the people who had done the work for them, a "thank you" cocktail and dinner party was given for newspaper reporters, feature writers and radio script writers after National Hospital Day was over.

More Cooperation Needed

The good will developed with the press, the radio and civic leaders is evident the year around. Recently, one of the papers had picked up an unfavorable story on hospitals and the E.M.I.C. program from a national labor journal. What was happening in St. Louis was a natural question. The reporter was invited to attend a meeting of the council where she received straightforward answers from the hospital administrators and was given a record of the number of hospital cases cared for under this program. She was also referred to the proper medical men for information on cooperation among the doctors. As a result, the story that appeared in the newspapers was extremely favorable to hospitals where it might have been quite damaging.

During war time, particularly, the problems of hospitals and hospital administrators are many and complex. Relations with allied professions are of paramount importance and special joint committees representing the medical societies, nursing and the hospitals are working constantly toward better relationships.

The Blue Cross plan of St. Louis has cooperated wholeheartedly with the hospitals in making its facilities available. The board has allowed both Mr. McCarthy and me to give unstintingly of our time in the belief that the Blue Cross should be the service arm of the hospital in deed as well as in word.



FRONT VIEW OF SIMMONS EDUCATIONAL BUILDING

LEFT: DEMONSTRATING THE ART OF NURSING
RIGHT: CORNER OF A CLASSROOM

To Teach the Art of Nursing

C. DeWITT MILLER
Superintendent
Orange General Hospital
Orlando, Fla.

EDUCATIONAL facilities for approximately 100 student nurses are provided in the Rose Simmons Educational Building of Orange General Hospital at Orlando, Fla.

The building was constructed and equipped at a cost of $10,000, most of which was made available through a bequest from a member of the board of trustees. The remainder of the sum was appropriated by the hospital.

The educational building houses classrooms, laboratories for teaching science, dietetics and nursing arts and a recreation room.

Two courses are offered to the student nurses at Orange General. One is a three year course leading to a diploma in nursing and the second is a combined course in liberal arts and nursing, which has been arranged in cooperation with Rollins College at Winter Park and John B. Stetson University at DeLand. These courses lead to a degree and diploma.

Above: Students learn about nutrition in the dietetics class. Below: The ping-pong table is a popular feature of the recreation room.

Alcoholism IS *a Hospital Problem*

MORRIS HINENBURG, M.D.
Administrator, Jewish Hospital, Brooklyn, N. Y.

THE problem of alcoholic patients has never been generally grasped or understood by those concerned with the conduct of the general hospital. It may therefore appear to be novel for a hospital administrator to undertake seriously the elaboration of a practical hospital program for the care of such patients. Nevertheless, the problem cries out for solution and we can no longer ignore it with safety to our over-all standards of hospital service.

I must frankly confess that my knowledge and experience with such patients, in common with representatives of my profession, have been limited to cases of alcoholism brought into the emergency room by the ambulance service for first aid, before transfer to a city hospital where facilities for sobering up purposes may or may not be maintained. No one ever seems to be interested in the fate of such patients. Indeed, the feeling is one of relief that the buck has been successfully passed.

There's the Drunken Employe

There is also the problem of drunken employes in hospital service, since healthy manpower has become so scarce in civilian life. The usefulness of these employes to the sick is either partially or completely suspended for varying periods of time. Faced with a choice of no service at all and inefficient service from this group, hospitals now follow a policy of compromise by permitting resident alcoholic employes to undergo their sobering up in the dormitory. This situation is tolerated because we are practically confronted with Hobson's choice. No wonder that the harassed hospital administrator has reached the point where he will grasp at a straw. Let us now see whether we cannot furnish him with a stronger reed to lean upon.

With the background of an organized experience in the care of patients generally, what can the hospital contribute to this neglected type of patient? Can the knowledge and experience of hospitals, closely integrated with the knowledge and experience of its professional groups that will be involved in the medical and related care of these patients, help in the elaboration of a sound hospital program for alcoholics within the scope of their activities? It is my firm belief that this can be done, with the understanding that the project is experimental and subject to modification.

One of the first steps in the program is to enlist public interest in the gravity of this public health problem. With the imperative need for the hospitalization of selected patients (excluding the psychotics) emphasized repeatedly, the governing boards of hospitals, representing the community in such matters, must consider the extension of hospital facilities for the care of these patients in institutions now generally closed to them.

The function of a hospital is to serve the sick and injured. The exceptions to this traditional rule are of our own making and can therefore be unmade. The general hospital exercises a legal right to select for admission cases that are clinically interesting and the needs of which for active medical and nursing care can be met within relatively short periods of time. This time-honored privilege of the general hospital may restrain ready acceptance of the alcoholic in these institutions, but a start once made under optimum conditions should serve to overcome prejudices against such patients.

Within certain limitations hospitals have adjusted themselves to progress in the medical sciences. This means, of course, that governing boards have the ultimate power to initiate changes in response to the needs of the community. The alcoholic who needs hospital care deserves a share of the attention that is now lavished so jealously on the more fortunate illnesses. The hospital must again take leadership in the development of the policies and practices that will lead to the physical, psychological and social restoration of these patients.

Public Interest Needed

A compelling evidence of public interest would stimulate hospitals to provide the scientific care now denied to this group. It would give strength to the belief which is gaining ground that alcoholics are in need of hospital care and must be given an opportunity to exploit every chance for their recovery and rehabilitation. Whether alcoholism is considered a disease entity, such as poisoning by a toxic substance, or is a symptom of an underlying neuropsychiatric disturbance makes no difference. The alcoholic is a sick person, in search of a rounded program of medical, surgical and psychiatric care. The optimism that is characteristic of the practice of medicine in hospitals should spread its sheltering wing over these patients too.

A positive response by hospitals to this challenge will be a long step forward in the rehabilitation of these patients. The degree of success that will attend the effort will depend on the extent to which all of the facilities of the hospital are used for this purpose. When hospitals will assure these patients facilities for medical diagnosis, supplemented by a complete program of therapeutic care

Address delivered before the Institute of Alcoholism of the Research Council on Problems of Alcohol, June 1944, New York City.

along with well-organized nursing services, medical social service and occupational activities, we shall be on the way to a constructive service for these patients and their neighbors.

A definite goal set out for these patients, with the tangible evidence that the resources of the hospital are being mobilized on their behalf, will bring the active and intelligent cooperation of these patients with the professional groups that care for them. The philosophy of a hospital program for alcoholics must be clearly outlined for these patients so that their participation will be that of active participants rather than that of passive recipients.

Include Special Hospitals?

At this point, the question may be raised as to whether a program for such patients should be limited to the general hospital. Should the special hospital be included? The special hospitals in our midst are in the fields of special surgery, cancer, tuberculosis, the head specialties, obstetrics, orthopedics and psychiatry. The special proprietary hospitals for the care of alcoholics are in an obscure class by themselves.

Because of the specialty nature of the work, a special hospital is geared to meet the needs of a limited group of sick and injured and usually lacks the diversified medical staff and the essential equipment and services to do full clinical justice to patients who present other types of medical and surgical conditions. The general hospital, with a comprehensive diagnostic and therapeutic program and a balanced relationship of its departmental units, offers the best facilities for the care of alcoholic patients.

Without a survey of the alcoholic patients in a community, it is not easy to estimate the number that requires hospital care in developing such a community program. Without this essential information it would be best, for present purposes, to resort to an empirical formula that will at least approach the need at a minimal level.

I would therefore advocate a working unit of 2 per cent of a hospital's capacity under an arrangement that would be flexible enough to permit the utilization of these beds by either sex without conflict. It is both desirable and economically sound hospital and medical practice to house alcoholics in conveniently accessible

Doctor Hinenburg offers a practical program whereby the care of the alcoholic can be brought within the scope of the general hospital

units. The day has passed when almost any type of accommodation may be used for an allegedly undesirable group of patients.

When we consider the principles that should govern the care of the alcoholic patient in hospitals, these must be established on broad and generous grounds. Thus, the needs of the patient must be met on an individual basis and any group treatment that is resorted to should be based on the interests of the individual. These concepts have a direct bearing on the construction, equipment, organization and administration of the hospital section to which these cases are assigned.

Separation rooms and small ward units of two or three beds appear to be ideal for these cases. These patients, when admitted in an acutely alcoholic phase, are likely to be noisy, unruly and unpleasant. Other patients should not be exposed to annoying sights and sounds. Their morale, too, must be kept up. The rooms should be substantially constructed along the line of modern psychiatric institutions, well ventilated and with sound-absorbing materials to reduce the volume of sound that may otherwise be disturbing in other parts of the hospital.

There are a number of essential considerations in the planning of the medical staff organization for this purpose. There is an opportunity for coordinated teamwork by the internist, the surgeon, the neuropsychiatrist, the chemist and the clinicians in charge of the ancillary services of the hospital. Clinical conference programs, which are a regular feature of medical organization in hospitals, should include alcoholic cases on the agenda.

At the outset an alcoholic patient should be regarded as a general medical patient. The routines generally observed to obtain the complete medical history and to determine the organic and functional factors that have a bearing on the plan of treatment should prevail. Any departure from the established routine of hospital practice in conducting a thorough clinical investigation may result in the failure to obtain vitally essential information.

The members of the medical staff assigned by the medical service to the care of these patients should have an active interest in the field of alcoholism. Through frequent consultations, their views can be correlated with those of the other specialists for a more productive understanding of the alcoholic patient as a whole.

The steps that suggest themselves in the hospital care of the alcoholic are:

1. The sobering up process in the case of the acute alcoholic. (This is a specialized form of first-aid treatment.)
2. The building up process to start the patient on the road to recovery.
3. The comprehensive medical and psychiatric investigation that will disclose the organic and functional disorders which may be responsible for the patient's condition.
4. The development of a medical plan for the continuity of essential treatment right into the follow-up phase.

Patients Will Cooperate

These stages are not separate; they may often overlap and one may continue while another is started. These steps, with the help of diversional and recreational activities, will influence the patient with the desire to aid in his cure.

Once the primary purpose of treatment is met, the medical staff should explore the educational and research opportunities under optimum scientific conditions. The resident staff, during the formative years of clinical training, will gain an appreciation of the problem that will support the future development of the program. In the early days of planning it would be well for members of the staff to visit established facilities for the care of alcoholics in order that they may learn at first hand how to help and how to avoid mistakes. This should reduce the hazards of a trial and error method.

Then, too, the prevention of disease in these patients becomes a factor of considerable importance. The

alcoholic is more susceptible to the communicable diseases than is the average patient. His lowered resistance, his disturbed nutritional health and the pathological changes in his body may result in serious complications, traumatic and otherwise. Any reduction in the incidence of alcoholism through curative practices, through educational programs, by example or achieved by other methods will influence morbidity and mortality statistics favorably. The reduction in the incidence of alcoholic psychoses would be a notable contribution to public health.

Must Be Vigilant

The nursing services for these patients should be adequate and, if possible, should be, in part, of a specialty character resembling psychiatric nursing. The male nurse with psychiatric nursing experience should be the backbone of the nursing service and this should be integrated with the rest of the nursing service in a way to provide training in this special field. The alcoholic patient needs constant watching and constant vigilance should therefore be a standing order.

Scientific treatment in the sheltered environment of the hospital, combined with hospital facilities in general, increases the possibilities of the patient's return to normal health. The trained medical social worker, with experience in psychiatry, is an important professional asset in such a setup. Working closely with the medical staff, she can assemble the personal and social data that will assist in the diagnosis and the plan of treatment. She can establish and maintain contacts with the family for information to understand the patient better.

Information about early family life, school, friends and acquaintances, work experiences, marital adjustments and the many other factors of modern life are basic instruments in fashioning the program for the alcoholic. His capacity for optimum adjustment based on his past experiences may serve to define the goal for which these organized services may strive.

The medical social worker should sit in on the therapeutic conferences held by the medical staff, as well as the progress and discharge conferences, where all pertinent data are reviewed and new developments are evalulated. She should make full use of the facilities of agencies organized to meet the essential welfare needs of the family and help make the essential family adjustment to provide an optimum environment for the discharged patient.

On discharge, the patient must be provided with an opportunity to discuss his problem freely with the rehabilitationist who is trained and who understands his problem, as well as the causative factors that may yield to intelligent control.

After a varying stay in the hospital these patients should be assured of a continuity of care in well-organized clinics of the hospital's out-patient department. Patients who possess adequate financial means may turn to physicians of their choice for this essential care. Patients of moderate means should be assured of these services through community resources.

A relaxation of the financial standards of eligibility for admission to such clinics will enable the private patient to obtain the advantages of a coordinated and balanced program of care under conditions that will not disturb the traditional relationships of such patients to their physician. The need for psychiatric care may predominate and should be provided for in the after-care program. Here the time value and recognition of psychiatric diagnosis and treatment can be measured.

It should be the goal of a hospital program for alcoholics to return each one of them to a position of self-respect and self-support. And the assurances for this are strengthened considerably when after care is provided to help the patient avoid the pitfalls in the path of his recovery.

A practical hospital program should be designed to meet the needs of (a) wealthy patients, (b) patients of moderate means and (c) patients without any means to obtain such care through their own resources. Philanthropic funds and tax funds and the funds of Blue Cross plans, by the acceptance of these illnesses as compensable, invested in a program of rehabilitation of alcoholics will bring a substantial return to the community.

Before closing, I wish to make a brief reference to the budgetary implications of placing 2 per cent of a hospital's beds at the disposal of alcoholic patients. If this were to be done in a 500 bed hospital, the 10 beds in the designated unit would add but little to the expenses of the institution. Nursing services of a specialized character and a more general use of the ancillary services will not add materially to the per diem cost of hospital service.

From the latest report of the United Hospital Fund covering the activities of its member hospitals, the following figures representing the income and cost per day for private, semiprivate and ward patients indicate the financial experiences to be anticipated in the care of these patients:

	Average Income per Day	*Average Cost per Day*
Private Patient	$13.25	$9.25
Semiprivate Patient	8.71	7.22
Ward Patient	3.66	6.98

The differentials existing between income and cost per day for patients in the private classifications will permit a hospital to observe its prevailing rates for the care of alcoholic patients. The ward patient, unable to meet the costs of hospitalization, should receive the same consideration that other patients in similar economic circumstances are accorded in other divisions of the institution.

Cost Is About $25,000

The average annual budget for a 500 bed hospital calls for an expenditure of approximately $1,000,000. The cost of a 10 bed unit for alcoholic patients may be estimated at $25,000 per annum, a figure that includes a reserve for unusual services. The annual income for a 500 bed hospital approximates $850,000, representing a loss in operations of $150,000. The deficit that may be charged to the conduct of an alcoholic unit may be estimated at approximately $8000 per annum, if the factors governing the distribution of patients in their several classifications and the ratios of income are similar to those for other patients in the hospital.

From a hospital standpoint, the budgetary considerations should prove to be the least significant.

These are the bare bones of the skeleton of a program to which healthy tissue may be added by more detailed planning, organization and education. We must agree on a start and keep the ball rolling till we achieve the goal.

To cook hamburgers and coffee and really eat outdoors is fun for all.

Recreation Therapy—

An Impetus to Normal Living

VIRGINIA MAY CURRY, R.N., and MARIAN A. WILDER, R.N.

Graduate Students in Advanced Psychiatric Nursing Course, Sponsored by University of Minnesota School of Nursing, Rochester State Hospital, Rochester, Minn., and The Mayo Foundation, Rochester, Minn.

RECREATION has a definite therapeutic value in all hospitals, especially psychiatric hospitals. Most state hospitals have had to curtail their recreational programs because of the acute war-time shortage of personnel. Therefore, it has been necessary for these hospitals to carry on with a limited amount of recreation for patients.

At Rochester State Hospital, Rochester, Minn., we are attempting to rebuild a recreational program which had been extremely limited owing to a shortage of personnel. Many patients still speak of the days when they participated in dances and picnics, although for several years they have had no planned recreation other than movies and the Fourth of July dance.

After only a few weeks of planned recreational activities, we are happy to see patients enjoy games that we have taught them. The games they play are those which they formerly enjoyed and had forgotten.

The postgraduate nursing students of Rochester State Hospital have taken over the recreational program as a vital part of their experience in practice teaching and supervision as members of the advanced psychiatric course given by the University of Minnesota School of Nursing.

In the beginning of our program we organized practice periods for the graduate students. In these periods we learned the simple dance routines which later were taught to the patients. Our recreational program has been planned so that senior cadets can carry on with patient recreation and actually see the values of such a program.

Our initial plan has been to hold a recreational class with three wards a day on three days a week. In this way we are able to provide entertainment for the wards three times during a two week period. As our program progresses, we will cover additional wards and gradually take in all of them. It has been necessary to formulate our plans according to the weather—one plan for sunshine and one for rain! In this way a sudden change in weather does not interrupt our recreation.

Before taking patients off the wards for walks and outdoor games, it is necessary that everyone be aware of the precautions that must be taken. Two nurses in each group are assigned to count the patients in and out with the ward head nurse. We have our patients walk in two's so that a count can be taken rapidly, and the nurses space themselves in order adequately to observe the entire group.

At times it has been necessary for us to walk on automobile roads, and we have been especially careful to walk on the outside so that patients will not succeed if they attempt to jump in front of a car. We avoid water and bridges and watch as unobtrusively as possible to see that our patients do not pick up any article that they might later use to inflict injury on themselves.

Much of our recreation has been short walks for patients who otherwise would be unable to leave the wards because of lack of supervision. The young patients enjoy active participation in soft ball games while the older patients make up the cheering section.

The patients are eager for their recreation hour because it breaks up the dull hospital routine and gives them more opportunity to be outdoors. One woman stated, "It makes the morning go so much faster; before I know it, it will be time for lunch." After an hour of supervised ward games, a patient confided that she now had something different to write in her letters to the family at home.

We have a small flower garden in which the patients have planted various flowers. Gardening brings the patient close to nature and gives him an opportunity to see the flowers grow and bloom. A patient who has had flower gardens before entering the hospital especially enjoys working in our garden because it brings back pleasant memories. As he works in the garden, he tells of the flowers

that he grew at home. Gardening provides a universal appeal because it consists of simple tasks that have been done since primitive times, and the patient actually sees the flowers thrive under his care and is pleased and gratified.

Much potential therapy lies in the outdoor world. As Charles Dudley Warner has said, "To own a bit of ground, to scratch it with a hoe, to plant seeds and watch their renewal of life—this is the commonest delight of the race, the most satisfactory thing one can do."

Exercise uses up energy that might otherwise be used in destruction.

Our indoor activity is carried on by two or more nurses who go to a ward to lead group singing and supervise card games, bingo and various other indoor games. We have found that group singing is an excellent means of beginning our ward activities because it stimulates the patients and gives them the feeling of actually taking part in something that everyone else is doing. Enthusiasm is infectious and the leader of the games is directly responsible for the interest shown by the group.

Our patients have developed a sense of responsibility in regard to caring for song books and games. By explaining to them the scarcity of equipment and asking their assistance in caring for it, we have been able to keep our song books and games in fairly good order.

Gradually, we are acquiring a collection of records which we plan to use on various wards with a portable phonograph. An evening on one of the wards for depressed patients is surprisingly lively since they have had a phonograph. The younger patients who like to dance have encouraged the older patients, and now the evenings are full of good music.

Soon after the ward received the phonograph, one of the young women was transferred to a parole ward. When asked how she liked her new ward and her increased freedom of the grounds, she said, "I would like to go back; we were just beginning to have fun, and then I was transferred."

During the summer, a picnic was arranged once or twice a week. From 4 to 8:30 p.m. a group of 40 or 50 patients with some senior cadets and a graduate nurse gathered to take the well-filled picnic baskets "up to the fireplace." The picnic ground is on a wooded hill not too far distant, with a level space that lends itself to group games and singing after supper. "To cook hamburgers and coffee and really *eat* outdoors, isn't it fun?" The outspoken appreciation voiced by many patients is the best recommendation for such simple recreational endeavors as these.

Recreation is recommended for everyone and not only the mentally ill. Many of our patients have had little time for recreation previous to their hospitalization and the idea of play is relatively new to them. In our program we do not attempt to change introverts to extroverts, but we do try to interest the patient in taking part in the activities of the group.

In a group that is enjoying calisthenics, the withdrawn patient must respond to what is going on about him. The disturbed patient uses in play part of the energy that he might otherwise attempt to use in destruction. After spending an hour out of doors, the most disturbed patients are much quieter and easier to care for. We have found them less quarrelsome and more relaxed outside than they are on the wards.

In planning a program of recreation, the patients' interests should be one of the major considerations. An observant nurse can detect when interest begins to lag and should be able to change the activity to one that will hold the patients' attention.

By keen observation and talking to various patients, the recreational therapist can gain insight into the activities the patient most enjoys and thus encourage initiative and free choice. Do we not all enjoy recreation of our own choosing? It gives a mighty impetus to this essential factor in all normal living.

CONVENTION DIGEST

Prepared by

RAYMOND P. SLOAN
ALDEN B. MILLS
MILDRED WHITCOMB
JANE BARTON

Assisted by

BESSIE COVERT
PEARL FISHER
NELLIE GORGAS
EVERETT W. JONES
MOIR P. TANNER

WITH a record-breaking attendance for a war conference, with the second largest exhibit in history and with substantial educational programs in most sessions, the forty-sixth annual convention of the American Hospital Association and of associated groups passed into history without any outstanding events to mar the smooth course of its flow.

Dr. Peter Ward, superintendent of Charles T. Miller Hospital, St. Paul, Minn., was chosen as president-elect.

There was no big and burning issue before this convention comparable to the dues increase and the tense relations between the federal government and hospitals which were so dramatic a year ago.

Probably the biggest solid accomplishments were made in the sessions of the Blue Cross plans which agreed with practical unanimity to promote a specific national contract, to provide full reciprocity among themselves and to have a standard procedure to encourage veterans to enroll. There was also a great deal of discussion concerning the need for building up medical and surgical plans so that they could be sold cooperatively with Blue Cross.

The impact of war on the conference was less noticeable in some ways but more so in others. There were fewer uniforms visible among the delegates and speakers; some of those in attendance, like Dr. Basil C. MacLean, had just donned "civvies." Long lines stood outside all eating places, cigarettes were hard to find, the best meeting halls at the auditorium were taken by the opera and other events so that many of the hospital sessions had to be held in rooms that were too small and were noisy and poorly ventilated. This was particularly regrettable for the small hospital section and the nursing section, both of which had attendance far exceeding the capacity of the hall.

George Bugbee stated that the association has grown to the place where perhaps it can hold conventions successfully in but one or two of the large cities.

House of Delegates

No sharp conflicts marked the sessions of the house of delegates, except briefly over the question of a statement of policy for the association. While the delegates seemed to be rather dissatisfied with the statement that had been prepared and submitted to them by the trustees, they finally accepted it without any significant opposition after some minor amendments had been made.

When the policy statement was first presented there were numerous delegates who considered it insufficient. A special committee was appointed to revise it.

The changes approved resulted in making section II-c read: "Research—medical care and hospital management" and section III-b read: "Local, county, state and federal government aid for the care of the indigent with emphasis on local participation." Section III-c reads, after amendment: "Government aid for public and voluntary hospital construction upon evidence of unmet needs." Section III-e reads: "Extension of inter-hospital coordination and cooperation both urban and rural."

PETER WARD, M.D.

A few other deletions were made.

More interest was manifest in the statement of relationships between hospitals and their radiologists, anesthetists and pathologists. After some backing and filling and considerable parliamentary maneuvers, it was decided to reaffirm the principles of relationship as these were stated in 1939. This action was in entire harmony with the action of the American Medical Association and yet avoided any further commitment as to where the responsibility rests for deciding local arrangements.

The American Medical Association had adopted a joint conference committee report stating that "the decision of any individual hospital should be determined by agreement between the administration and the medical staff of such hospital." This statement was merely received and filed.

President Walter presented a report on the year's work full of substantial achievements. Among other things he told the delegates that the A.H.A. has established an educational trust to which gifts can be given for administration by the A.H.A. that will be tax-free. Numerous joint programs are under way with the U. S. Chamber of Commerce, U. S. Public Health Service, Farm Foundation, American Red Cross and various professional organizations.

Aside from the resolution on health insurance reported elsewhere, no significant resolutions were adopted by the delegates. A resolution on the care of the chronically ill and another on medical social service were referred to the appropriate councils.

Committees

Principal committee appointments of President Donald C. Smelzer give new positions on councils to 11 persons and reappointments to 10. One, who served only a part of a term and was appointed to a full term, is considered as a new appointment.

The council appointments (with an * for those who are new) are as follows: **governmental relations:** John N. Hatfield,* chairman, Philadelphia; Dr. Fred G. Carter, Cleveland, and Gerhard Hartman, Newton Lower Falls, Mass.; pro-

fessional practice: Dr. Robin C. Buerki, chairman, Philadelphia; Worth Howard,* Akron, and Dr. Willard L. Quennell,* Baltimore; **administrative practice:** Dr. Frazier Mooney, chairman, Buffalo; Guy Clark, Cleveland, and Charles G. Roswell,* New York City; **hospital planning and plant operation:** Dr. Frank Bradley, chairman, St. Louis, Dr. J. B. Whittington,* Winston-Salem, N. C., Dr. Albert W. Snoke,* Rochester, N. Y.; **association development:** O. G. Pratt, chairman, Salem, Mass., W. E. Arnold,* Florida, and H. J. Mohler, St. Louis; **international relations:** Dr. Malcolm T. MacEachern, chairman, Chicago, Dr. Edward C. Ernst, Washington, D. C., Dr. James A. Crabtree, Washington, D. C.; **public education:** Reginald Cahalane, chairman, Boston, Stuart Hummell,* Joliet, Ill., and Priscilla Campbell,* Chatham, Ont.

Other new appointments by President Smelzer include: Dr. B. W. Black, Oakland, to the nominating committee for a five year term; Dr. Henry Pollock, Boston, chairman, Msgr. Maurice F. Griffin and Dr. A. C. Bachmeyer to the committee on award of merit; Graham L. Davis, Battle Creek, Mich., as chairman of the committee on by-laws;

The committee on postwar planning was reappointed.

A trustees committee on pension plans was appointed with George U. Wood of Oakland, Calif., as chairman.

A.H.A. Trustees

Authorization for a new council on education to study the educational activities of the American Hospital Association to be sure that they are effective was voted by the trustees during their session in Cleveland.

Although the education of hospital administrators has been left to the A.C.H.A., the A.H.A. has undertaken institutes for purchasing agents, personnel managers and accountants. Much talk has concerned possible institutes for public relations officers. Of course, administrators who are interested in these subjects also attend these institutes.

A committee of three was authorized to approve any self-supporting institutes that may be formally proposed by the coordinating committee.

The trustees decided, after canvassing a vote from the Canadian members, to keep dues for Canadian hospitals at the same level as during the past year, namely 66 per cent of the dues in the United States.

A.H.A. manuals will be translated into Spanish by the Inter-American Hospital Association with A.H.A. approval.

A proposal was tentatively approved that may later become legislation in the various states. It proposes state study of medical and health needs by the various states themselves and possible federal grants-in-aid to the states for postwar hospital construction as part of a public works program.

The statements by Dr. Claude W. Munger and C. Rufus Rorem before the Pepper committee of the Senate are to be distributed to the membership, the trustees decided.

Approval was given to a project sponsored by John H. Olsen, Richmond Memorial Hospital, Staten Island, N.Y., for a "Stamps for Wounded" campaign whereby stamps would be collected for wounded veterans.

Plaques expressing the appreciation of the A.H.A. to the various hospitals that have had administrators as presidents of the association were authorized. Such plaques will go, in the first instance, to New Haven Hospital, New Haven, Conn., and St. Luke's Hospital, Denver.

READING FROM TOP TO BOTTOM:

- **John H. Hayes, Lenox Hill Hospital, New York City, and Dr. Thomas Hale, Albany Hospital, Albany, N. Y.**
- **Lois Corder, University of Iowa Hospitals, Iowa City, and Lt. Fred Graham, M.A.C., Camp Crowder, Missouri.**
- **Guy Clark, Cleveland Hospital Council, and John R. Smiley, St. Luke's Hospital, Kansas City, Mo.**
- **Pearl Fisher, superintendent, and Dr. Frederick Hill, president of the board, Thayer Hospital, Waterville, Me.**
- **A. H. Minnis, president of the board, and Thomas F. Sharpnack, superintendent, Broadlawns Polk County Hospital, Des Moines, Iowa.**

Health Insurance

Compulsory *v.* voluntary hospital and health insurance was discussed at various sessions of the meeting but the opinion of the house of delegates was expressed in a resolution adopted without opposition or discussion.

This resolution reaffirmed the house's "belief in the desirability and necessity of the widespread acceptance of the voluntary prepayment principle as a means of financing medical and hospital services" and it therefore approved "the collaboration of the Blue Cross plans with appropriate representatives of the medical profession to the end that the expenses of hospital illness be financed on a prepayment basis." No explanation was given for limiting the resolution to hospital illness.

Just before the adoption of this resolution, a packed session heard (as best it could over competition from the convention hall) a top-flight program on the broader aspects of health insurance.

LEFT: Sr. Mary Lourdes, St. Mary's Hospital, Rochester, Minn.; Sr. M. Venard, Trinity Hospital, Jamestown, N. D.; Sr. St. Ignatius, St. Joseph's Hospital, St. Paul, Minn., and Sr. Mary Quentin, St. Mary's Hospital, Rochester, Minn.

RIGHT: Ruth Taylor, Coatsville, Pa.; John Weaver, Lancaster, Pa., and Jane Boyd, Butler, Pa.

Perhaps the most outstanding of the four papers, and certainly one of the outstanding papers in A.H.A. history, was by Clayton W. Fountain, assistant to the vice president of the United Automobile Workers (C.I.O.). Other excellent papers were presented by Louis S. Reed, who is in charge of the U. S. Public Health Service study of Blue Cross plans, Louis Pink, president of Associated Hospital Service of New York City, and Gregg L. Neel, insurance commissioner of the Commonwealth of Pennsylvania.

Mr. Fountain opened up by declaring frankly that the U.A.W.-C.I.O. is on record in favor of the Wagner-Murray-Dingell Bill. "I announce this as a matter of putting my cards on the table."

But labor does not want the state to take over direction of all social functions including medicine. "Labor supports the bill because private agencies in the medical field are not doing a proper and adequate job of insuring the health of the common people of America. It is strictly a practical problem with us," said Mr. Fountain.

"You will not change our minds on this issue by talking in terms of socialized medicine, bureaucracy, regimentation or all the other semantic nonsense with which this controversy has been cluttered. Joe Worker wants health and he is going to get it one way or another. You cannot turn him aside from his quest by stuffing him with arguments against bureaucracy and regimentation. If you don't do it, he turns to the state. Where else can he go under a democracy?"

Perhaps Mr. Fountain let the cat out of the bag, however, when he told the audience to go out and organize a better and less costly service than the government can supply. "If you do that kind of a job, you will have met the arguments for federal health insurance. Until then, we are going to stand pat on our support of the Wagner-Murray-Dingell Bill."

While praising Blue Cross for what it has done and for fine cooperation with his union, Mr. Fountain also criticized the plans for the lack of subscriber representation on the board and the staff and inadequate subscriber education.

In general, a good report on the work of Blue Cross plans was presented by Mr. Reed on the basis of his study which is now about half completed.

John Mannix proposed again the formation of an American Blue Cross corporation, to be controlled by the A.H.A. and the A.M.A., together with other professional groups if they are concerned. No action was taken on this.

While disclaiming any criticism of Mr. Mannix' proposal, Mr. Pink stated that it is so vast as to "give pause even to the daring." He thought it might be easier to incorporate an insurance company.

Nursing

They aren't just one big happy family, it seems—the registered nurses and the vocational nurses. Just in case you don't know what vocational nurses are, no need to apologize. "Vocational" is the accepted new term for auxiliary or practical nurses.

Registered nurses won't always eat in the same dining room with vocational nurses. Registered nurses often accept them only because so much work is piled on their own shoulders that they are willing to forget professional and social caste to get some assistance. Down South vocational nurses are colored and that apparently assigns them automatically to "their place."

This post-program reference to feuding between the new and the established groups on the hospital wards climaxed an uncommonly good program at the nursing section. It brought Hilda Torrop of the practical nurses' group to her feet to fight for her cause, asking that professional nurses be taught to look a year or two ahead to decide whether they want to spend a mere fraction of their ability and education on nursing hordes of chronic and convalescent patients who can be nursed by the vocational group with complete satisfaction to patients and to practical nurses.

It brought Mrs. Elmira B. Wickenden to her feet to explain that nursing leaders recognize the future, as well as the present, rôle of the vocational nurse and that little by little this attitude will reflect itself in the thinking of the rank and file of registered nurses.

The smart cadet corps uniform on the platform was not Lucile Petry's for she couldn't come but Jane Taylor wore both the uniform and the substitute rank well. For it was she who read Miss Petry's thoughtful paper and answered queries with precision.

Miss Petry's message was that the emergency training of nurses won't result in an oversupply. These war-trained nurses will be needed in psychiatric hospitals where 500,000 civilians await professional personnel to give them the chemical and shock therapy being used to treat cases in the armed services. They will be needed in the clinics connected with hospitals and health centers. They will be needed in the enormous expansion program of veterans' hospitals, where the nurse supply is already a thousand short. They will be needed in nurse education where one fourth of the teaching and supervisory jobs are unfilled and where resort has been made to ill-prepared substitutes.

Mrs. Wickenden of the National Nursing Council for War Service gave the latest estimates on nursing needs. For July 1946 the estimated needs total 390,000 nurses. By that time there will be 261,000 graduates active and available, thus producing an evident shortage of 129,000. This lack will be made up only in part by student nurses, the council believes.

Once past his amusingly pessimistic beginning, Dr. H. M. Coon, superintendent of the State of Wisconsin General Hospital, Madison, made it clear that good personnel relations do count. But in these war days he painted an unhappy picture of shortage regardless of the strength of the personnel policy.

Doctor Coon puts good salaries in fourth place on his list of essentials for a happy nursing staff. First, he thinks, comes understanding, the understanding



LEFT: W. W. Butts, St. Luke's Hospital, Bethlehem, Pa. CENTER: Katherine Hennessey, Stouder Memorial Hospital, Troy, Ohio. RIGHT: Rev. L. B. Benson, Bethesda Hospital, St. Paul, Minn.

that there will be a square deal for all from the hospital administration.

Second, he would put satisfactory working conditions. Third comes freedom from other than purely professional work with details done by subsidiary workers. Then come adequate, fair and equitable salaries, followed by suitable sickness allowances and vacation leaves. Last he would place retirement security in the way of federal social security and insurance plans in which the hospital also participates financially.

Opening the session, Louise Knapp, director of Washington University School of Nursing, reported that hospitals may have to revise their earlier idea that the all-graduate staff is superior to the combined student and graduate staff.

Small Hospitals

The small hospital, like others, must pay adequate salaries, preferably in cash, to attract attendants or nurses and, in addition, must offer an opportunity for increases in salary and responsibility. Eva M. Wallace, superintendent, All Saints' Hospital, Fort Worth, Tex., speaking before the small hospital section, expressed the opinion that the hospital administration should see that employes are kept informed, provided with proper initial job instruction and with subsequent supervision. Local newspapers she has found the most successful means of attracting former nurses back into service.

Continuing on the subject of personnel, A. A. Aita, administrator, San Antonio Community Hospital, Upland, Calif., emphasized the fact that personal personnel policies pay dividends by providing stabilized hospital service and assuring loyal and cooperative workers. Particularly will individual consideration to sick leaves, time off and vacations prove helpful. Postwar plans for San Antonio Hospital include three months' postgraduate work to interested department heads at the hospital's expense. The hospital also provides frequent entertainment and get-togethers.

There is nothing like starting the patient off right, according to Paul Fleming, assistant director, New Haven Hospital, New Haven, Conn. Give him a neatly printed receipt for his clothes and attractive pamphlets to read explaining the mission of the hospital. He will likewise appreciate a picture postcard of the building to send to his friends. Let him know what he is getting and you dissipate the "bill-shock." Finally, two weeks after he is discharged send him a note of good wishes with the suggestion that you are open to any ideas he may have about improving the service.

Responsibility for improving the staff practice of the small hospital rests with the administration. In emphasizing this point Amy J. Daniels, superintendent, Elkhart General Hospital, Elkhart, Ind., laid particular stress on understanding staff psychology.

Awards

"Never before has the presentation of the association's annual award been made to an elected officer during the term of his office, so when the board voted the award to me this year I felt that I could accept only by presenting my resignation to the board. President Walter, as presiding officer, you have my resignation, you have heard my valedictory."

With this gesture, the more dramatic because it came as a complete surprise to the large audience that filled the Statler's grand ballroom, Rt. Rev. Msgr. Maurice F. Griffin, senior trustee of the A.H.A., closed his acknowledgment of the annual award of merit which was presented by Dr. Henry M. Pollock, Massachusetts Memorial Hospital, Boston, during the presidents' session.

It was President Walter's judgment that it would be useless for him to submit Monsignor Griffin's resignation to the house of delegates because he was certain that it would not be accepted.

Awards for public education programs, formerly presented in connection with National Hospital Day, were given to the following state associations and individual hospitals.

The statewide program award was presented jointly to representatives of the Illinois, Michigan and Minnesota hospital associations.

Citywide honors went to St. Louis, with Kansas City as a runner-up.

The individual hospital award for cities of more than 100,000 went to St. Luke's Hospital, Chicago. Honorable mention was given to Wyckhoff Heights Hospital, Brooklyn, N. Y.

For cities of from 15,000 to 100,000 the first prize went to North Adams Hospital, North Adams, Mass. Silver Cross Hospital, Joliet, Ill., and Blessing Hospital, Quincy, Ill., were given honorable mention.

For cities of less than 15,000 the award was won by Glenwood Community Hospital, Glenwood, Minn., with honorable mention for Public General Hospital, Chatham, Ont.

Dietetics

Greater opportunities than ever before await the dietitian in the postwar period. As Gladys Hall, executive secretary, American Dietetic Association, sees it more emphasis will be placed upon personnel, including job analyses. Consultation services in kitchen layout will be required, as well as in administrative procedures and food handling. Hospitals in which extensive teaching programs are carried on will find it necessary to employ additional dietitians. The administrative dietitian cannot carry the full load. State hospitals will require dietitians with special training including some knowledge of psychiatry. The dietitian of the postwar period will be, in other words, an administrative officer of the hospital working in complete cooperation with other department heads.

To promote thoroughly adequate sanitary precautions throughout the dietary E. B. Buchanan, chief of food and drug administration, Department of Health, Cleveland, suggested the appointment of a sanitary committee whose function it would be to make weekly surveys of the kitchen, the dining rooms, in fact, every part of the department. This committee might comprise a nurse, a doctor, the dietitian and a waitress. Mr. Buchanan's paper was presented by proxy because of his illness.

Should the hospital dietitian do the purchasing? It is a much debated question. However, it may be answered and whatever the policy of the individual institution she should know what she wants. Starting with this premise Margaret Cowden, director of dietetics, Michael Reese Hospital and Dispensary,

Chicago, proceeded to explain that the dietitian should have specifications as to quality, size, amount. Also, she should buy for the particular use. Although she doesn't set the budget she must adhere to it and should exercise efficient cost control. Too great care cannot be expended upon checking. Goods should be weighed and inspected for condition and quality.

Further information on the volunteer dietitian's aide corps was supplied by Mrs. Fred Rittinger, chairman, Red Cross Volunteer Corps. She announced that a junior dietitian's aide course is under way for juniors and seniors in high school who meet certain requirements.

Rural Hospitals

Anyone who questions the determination of our rural population to obtain the best possible health, hospital and medical service—and that very soon—would have had his last doubts dispelled by listening to the four speakers at the rural hospital planning session. What the farmer needs and intends to have, how the A.H.A. can help improve the rural hospital facilities, how one small hospital serving a rural community is planning its development and how the F.S.A. hospital care program has worked out were all discussed in a program that went off with machine-like precision under the chairmanship of Graham L. Davis.

The 200,000 farmers who comprise the membership of the farm cooperatives are not waiting for a miracle to bring them security; they are pooling their resources to provide protection for themselves, according to Mrs. Jerome Evanson, director of education, Farmers' Educational and Cooperative Union of America. As evidence of the fact she pointed to such developments as the Sand Hill Region Health Association, organized in 1942 by ranchers and farmers to provide prepaid health care.

Hospital needs of farmers can best be served, the speaker contended, by the establishment of modern centrally located institutions that serve a wide area rather than by many small hospitals. In these central hospitals should be included all the facilities for a modern health center.

Ways of helping the farm population to obtain the good health program it is seeking were outlined by Carroll P. Streeter, managing editor of the *Farm Journal*. The people of the nation must support any sound movement to put good rural hospitals in areas that need them and don't have them and bring substandard hospitals to a safe level, Mr. Streeter declared. But more than that, they must help farm people find a way to pay for health care which means, first of all, that they must support the farmers' attempt to have an adequate income.

The other side of the picture—what is being done, or planned, to bring good health to rural citizens—was presented by Harold F. Stock, president of Hillsdale Community Health Center, Hillsdale, Mich., and by Kenneth E. Pohlmann, health service specialist, F.S.A.

Mr. Stock, who joyously admitted to being the "voice of inexperience," having begun his hospital work only five years ago, believes that although Hillsdale does not yet live up to its name of "health center," it can be developed into a real health center for the 28,000 people it serves with a little foresighted planning.

The last speaker, Kenneth Pohlmann, started by explaining that he came "with two strikes on him"—he came from Washington and he represented the government. The F.S.A. in 1936 was faced with the problem of pioneering in medical care on a prepayment basis. With no previous experience, it had to provide a health service program in communities that were unable to provide for themselves. The program, which permitted participants free choice of physician, was carried out in cooperation with state medical societies. The services rendered vary according to needs and ability to pay. Yearly fees range from $5 to $15.

Mental Hospitals

His colleagues called it Utopia. He called it postwar planning. This reporter calls it history in the making.

Asked to lead a round table on postwar construction for mentally ill patients, Dr. J. Fremont Bateman, medical superintendent of Columbus State Hospital, Columbus, Ohio, with quiet majesty hurled a thunderbolt.

Doctor Bateman would freeze all construction of mental disease hospitals after inadequacies are corrected in certain areas and after buildings of the Kirkbride type are replaced. He would insti-

READING FROM TOP TO BOTTOM:

- F. R. Ostrander, Sheldon Memorial Hospital, Albion, Mich., and H. L. Snodgrass, Hartford Memorial Hospital, Havre de Grace, Md.
- Hazel Hallett, superintendent, and Mrs. H. B. Lane, board member, Little Falls Hospital, Little Falls, N. Y.
- Douglas West, District of Columbia Department of Health, and Louis S. Reed, U.S.P.H.S., Washington, D. C.
- Donald M. Rosenberger, Hamot Hospital, Erie, Pa., and Mrs. Rosenberger.
- Dr. Nathaniel Faxon, Massachusetts General Hospital, Boston, and N. C. Faxon, Cambridge, Mass.

tute a carefully planned program for prevention and early treatment and, since no stigma could be attached, would expect patients to go early to general hospitals where an adequate staff of psychiatrists and psychiatric nurses would treat them as they occupied rooms in scattered locations. Even the small rural hospital would have three or four beds for mental disease patients.

Separate wards would house the irrational. Cases of senile dementia would be placed in homes for the aged.

Doctor Bateman would confine his postwar planning to the training and education of adequate psychiatric personnel.

As it is, general hospitals are sending patients with conditions easily amenable to treatment to the beautifully landscaped "asylums" where those who enter lose their civil rights and their self-respect.

Another paper startled a far too meager audience with carefully garnered facts rather than with revolutionary ideas. Mrs. Laura Fitzsimmons of the research division of the American Psychiatric Association presented a sorry picture of the psychiatric nursing shortage.

In a two year study in the United States and Canada the lack of nursing care in mental disease hospitals was found to be appalling. One hospital in a rich state has 2864 patients and one registered nurse. Nor is this situation due to the war, Mrs. Fitzsimmons finds. The faults are: (1) lack of vision, (2) low budgets and (3) poor organization.

One state spends $14.88 per capita on patients in its mental disease institutions; the same state spends $21.89 per capita on its penitentiary inmates.

Antiquated organization prevents women nurses from crossing the threshold into the men's wards in many hospitals. Nor do the superintendents of nurses or heads of training schools have any authority over the attendants, who thus care for a large segment of the patient population.

Mrs. Fitzsimmons' paper was a plea to encourage the few remaining basic schools of nursing in mental disease hospitals to see that a psychiatric affiliation becomes a part of the training of every nurse, to establish postgraduate courses in psychiatric nursing and to establish uniform courses for attendants and practical nurses for psychiatric hospitals.

Insulin shock and metrazol therapy for cases of schizophrenia were reported successful in many age groups by Dr. Clarence H. Bellinger of Brooklyn State Hospital. Metrazol was found to be particularly efficient in the more protracted cases.

Electric shock therapy was found effective with patients suffering from manic depressive and involutional psychoses. In dementia praecox, electric shock was found not as effective as either insulin or metrazol.

Public Relations

Get your house in order before you try to sell it to the public.

An advertising man, a Salvation Army leader, a superintendent of industrial personnel and a hospital administrator would write pretty much the same ticket when it comes to hospital public relations.

John F. Hunt, a Chicago advertising man, told the public relations section that both the individual hospital and the nation's hospitals must find out—by the direct interview method preferably—just what the public thinks before they can begin any sound program of public relations. His firm, Foote, Cone and Belding, measured public opinion on hospitals in both California and Michigan.

In California 41 per cent of the people think hospital charges are too high; 35 per cent think the charges fair; 21 per cent, too low, and 23 per cent are of uncertain opinion.

Michigan hospital service fared better: 46 per cent think hospital charges fair; 22 per cent think them too high; 7 per cent, too low, and 25 per cent have formed no opinion.

Commissioner John J. Allan, territorial commander of the Salvation Army, thinks the best publicity for hospitals or any organization is to state their case as plainly and briefly as possible. The public has a better heart and head than it is supposed to have, and the hospital has an unmatched advantage in appealing to both the sympathies and the intelligence of the people.

A successful personnel worker with the International Harvester Company, Sara E. Southall warned that no public relations program can succeed unless employe relations are successful. The first step in a program is to examine internal affairs carefully, see that supervisors are using their authority according to the best technics, make employes feel that they belong, pay them fairly, see that there is no friction through the overlapping of responsibilities and sell employes the conviction that the venture is worth their while.

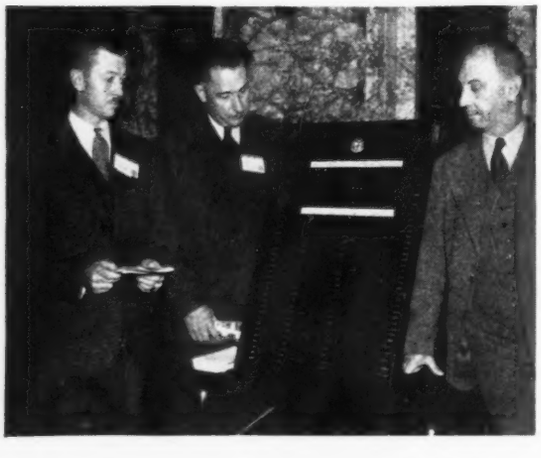
Dr. Basil C. MacLean, back in civvies, told the large group that hospitals are still suffering from a cash register complex that is neither sensible nor subtle. Public relations, he asserted, must be nurtured on private honesty.

Blue Cross

Adoption of a specific national contract for use in the enrollment of national accounts, adoption of a basis for full reciprocity among all Blue Cross plans, election of a new chairman of the Hospital Service Plan Commission and a prediction that all enrollment records will be broken during 1944 were highlights of an unusually harmonious and fruitful meeting of Blue Cross executives during the convention.

A greatly increased interest in working with physicians for the provision of medical service plans was also an important development.

The new national contract, which was overwhelmingly approved by the plan directors who promised to try to get it approved by their boards, provides thirty days of service in each contract year in a room of two to four beds and an addi-



LEFT: Harold C. Mickey, Duke Hospital, Durham, N. C.; Warren Irwin, Strong Memorial Hospital, University of Rochester, and Neal Johnson, Johns Hopkins Hospital, Baltimore, with A.H.A. exhibit of simplified list of hypodermic needles.

RIGHT: Mary Neman and Mrs. Kate Hard, Saginaw General Hospital, Saginaw, Mich., with William P. Butler, San Jose Hospital, San Jose, Calif.

tional ninety days at 50 per cent benefit.

In addition, the following benefits are available for each admission: meals and special diets; general nursing service; operating room service; anesthesia up to $10 per admission, if regularly provided and billed by the hospital; radiology up to $15 per admission, if regularly provided and billed by the hospital; clinical and pathological laboratory service; electrocardiograms; basal metabolism examinations; physical therapy; oxygen therapy; drugs used in hospitals and listed in U.S.P., N.F. or N.N.R.; biologicals and solutions; dressings and plaster casts; emergency room care for accidents.

Dependents are to receive the same benefits as are given employed subscribers and the same benefits are available in member hospitals of all approved plans. For hospitals that are not members of any plan the regular charges of the hospital will be paid up to $6 per day. Maternity service is covered up to ten days for holders of family contracts after nine consecutive months of membership but the waiting period is eliminated if 75 per cent of all employes enroll and if these equal at least 50 employes.

Preexisting conditions are also to be covered if 75 per cent of eligible employes enroll with a minimum of 50.

Care is to be provided for venereal disease cases, alcoholism and drug addiction and self-inflicted injuries. For quarantinable diseases care will be provided up to $3 per diem. For tuberculosis and nervous and mental conditions care will be given in member hospitals only up to thirty days per year.

The only conditions excluded are: (1) industrial accidents and diseases, (2) conditions for which care has been provided in a federal hospital or to the extent provided by a government agency for war injuries, (3) conditions not requiring admittance to a hospital and (4) physical therapy, x-ray and laboratory service unless incidental to hospitalization.

For more expensive accommodations, the subscriber pays the difference between the cost of the services used and those to which he is entitled.

Subscription rates are to be determined by local plans. The contract will be available only to employed groups of 50 or more without physical limitation, age or income limits or enrollment fee.

Plans agreed as a matter of reciprocity to provide their subscribers with the service benefits of the plan in whose territory the subscriber happens to be hospitalized, to permit that plan to pay its member hospital at its regular rate and to reimburse that plan for the amount so paid.

Extensive discussion of a national paid advertising and publicity program was held by the plan representatives. The 25 or more plans that have agreed to pay 1 per cent of their income for such a program were impatient to get started. It is still hoped that the program may be undertaken within the year.

Plans for a national enrollment office have already been approved and, probably, this will be undertaken shortly.

LEFT: James Best, purchasing agent, New York Hospital. CENTER: Dan Gay, Phoenixville Hospital, Phoenixville, Pa. RIGHT: David R. Kenerson, Clearfield Hospital, Clearfield, Pa.

Public Health

The walls of his institution are too narrow a confine for the modern hospital administrator. Unless he acquaints himself with public health philosophy and a knowledge of public health functions he is an anachronism. So also, the physician.

A couple of thousand administrators at Cleveland broadened their public health concepts at a significant general session on Tuesday morning through the intelligent and forward looking guidance of Dr. Hugo V. Hullerman of the A.H.A., Dr. J. R. McGibony of the Office of Indian Affairs, Dr. Julius L. Wilson of the American Trudeau Society and Dr. Morris Fishbein of the A.M.A.

Able Doctor Hullerman of the Council on Professional Practice pointed up six programs warranting the interlocking services of hospital and public health agencies: (1) the official immunization program of the community; (2) routine x-ray examination of patients to discover tuberculosis and cardiovascular disease, the former condition to be reported to the health department; (3) expansion of the cancer control program; (4) health examinations in hospital health centers as a part of the physical fitness program; (5) participation of hospital administrators in public health planning, and (6) patient follow-up. Federal and state health planning is not enough; community planning is essential for mass health progress.

Having conquered the disease himself, Doctor Wilson spoke with dual motivation on the grave injustice of the general hospital's exclusion of all persons with diagnosed tuberculosis when it handles patients with far more dangerous communicable diseases.

His five point program for tuberculosis control from the hospital angle follows:

1. Arrange to obtain chest x-rays of every patient at admission.
2. Set up criteria for admission (a) with isolation of active cases; (b) without isolation of patients with small lesions, and (c) rejections. These criteria should be standardized nationally.
3. Urge the A.H.A. to form a committee on tuberculosis to work on the problem and advise all the hospitals.
4. Urge each district and each hospital to set up a committee on tuberculosis to pass on the classification of patients.
5. Report all cases showing x-ray evidence of active tuberculosis to the local health department.

Doctor Fishbein reported on the physician's changing concept of public health as medicine has advanced. There has developed the great new speciality of industrial medicine as both employer and labor have seen the benefits of preemployment physical examinations and health check-ups. Group methods of diagnosis and group methods of treatment have even been introduced into the difficult field of neuropsychiatry.

The hidden battle as to who is to dominate the field of public health still goes on, Doctor Fishbein declared, with the physicians, the hospitals, the economists and the public health officials each claiming the control.

None of these groups should control public health, the A.M.A. spokesman asserted. It must be a completely cooperative effort, but medical understanding of disease must underlie every measure taken for the benefit of the public health.

An example of a total health service reaching from the cradle to the grave was presented by Doctor McGibony in the work of the Indian hospitals. The Indian birth rate is twice that of the population as a whole but the Office of

Indian Affairs is not worried over the future burden for the aim is the ultimate disappearance of government aid for the Indians.

Medical Records

The records librarians meeting was lively, informative and inspiring, with much wit from Sister Mary Patricia, the chairman.

Edna K. Huffman, Wesley Memorial Hospital, Chicago, led off with an excellent summary of the advantages of transposing records to film. The main advantage, of course, is the space saving. In addition, medical records on film cannot easily be tampered with, after filming, misfiling is impossible and microfilms are accepted by courts as primary evidence. They have a lifetime of approximately one hundred years. They burn no more quickly than paper.

Free discussion from the floor brought out what disadvantages there are to filmed records, principally some hurdles for research and the problem of converting the unit system records. It was pointed out, however, that strip film could be used, each strip being filed in envelopes with new strips added from time to time.

When a patient is readmitted, it would probably be necessary to review his previous record, thus requiring projectors to be readily available on each ward. A new technic is to make a duplicate film or reprint the record from film.

The audience was amazed when Dr. M. G. Westmoreland of the A.M.A. reported 729 more records librarians on hospital staffs this year than last, yet only 27 were graduated from the approved courses. At the present rate of 90 students in schools each year, it will require more than seven years to replace the untrained librarians added to this year's staffs. Many other vacancies are unfilled.

Heated discussion of ways of recruiting and training more records librarians included a statement by Dr. Roger De-Busk, Evanston Hospital, Evanston, Ill., that it is the responsibility of the records librarians themselves to convince hospital administrators of the need, of their opportunities and responsibilities for opening new training schools and providing fellowships and stipends for trainees.

Required reading for all hospital administrators should be the paper by Sister M. Loretta, St. Mary's Hospital, Duluth, Minn. She outlined the difference between a records clerk and a medical records librarian. Chief among these is that the librarian must see that medical records are actually used.

She is "not a filing clerk but a historian who anticipates the needs of her staff for study materials and devises ways and means of classifying the records," Sister Loretta pointed out.

Nellie Gorgas reviewed today's records in the light of A.C.S. and A.A.M.R.L. standards.

READING FROM TOP TO BOTTOM:

- **Dr. J. R. McGibony, health director, U. S. Indian Service, and Mrs. McGibony.**
- **Harry W. Smith, Columbus City Hospital, Columbus, Ga., and Mrs. Smith.**
- **J. F. Morrison, Clovis Memorial Hospital, Clovis, N. M., and John G. Dudley, Baptist State Hospital, Little Rock, Ark.**
- **George L. Davis, Nassau Hospital, Mineola, N. Y., and Irene McCabe, St. Louis Hospital Council.**
- **F. J. Bath, Creighton Memorial Hospital, Omaha, Neb., and James M. Dunlop, Wesson Memorial Hospital, Springfield, Mass.**

Medical Staff

Physicians in the armed services have been accustomed to providing their patients with all necessary treatment, including plasma, penicillin, sulfa drugs and other costly adjuncts. When they return to civilian hospitals they will expect the same.

This was one of two warnings issued by Dr. Victor Johnson, secretary of the A.M.A. Council on Medical Education and Hospitals. The other was that hospitals must nearly double the number of house officerships to meet the demands of physicians in the armed services.

Doctor Johnson urged that improved transportation of patients be considered as a possible alternative to the multiplication of small hospitals.

Lavish praise for the medical service of the Army Air Corps was voiced by Col. Howard A. Rusk, chief of the Convalescent Training Division of the Office of the Air Surgeon, Washington, D. C. Ninety-two per cent of the men who come under the care of the physicians are returned to duty or discharged in good condition, he reported.

Colonel Rusk said that 20,000,000 man hours of physical and educational training have been given in AAF hospitals since 1942.

Vocational rehabilitation was given extensive discussion, with Dr. Jack Masur outlining the program of the federal government for civilians and Dr. Harold A. Vonachen, medical director of the Caterpillar Tractor Company, Peoria, Ill., discussing the extensive use of disabled persons in that company. Even the chairman of the session commented that he was running a hospital and presiding over an important session although he had lost an arm.

A.C.H.A.

Complacency will not be one of the faults of the American College of Hospital Administrators if the organization accepts the various challenges thrown at it in a lively educational session on Monday morning. Three speakers, each one better than the one before, set off dynamite charges under the large audience of hospital administrators present at the session.

Herbert C. Hunsaker, dean of Cleveland College, pointed out that age is no barrier to learning. While the speed of learning reaches its peak at about age 23 and decreases about one per cent a year thereafter, this loss is often more than offset by the gain of experience and depth of interest.

An administrator should, by example and active promotion, encourage adult education on a continuing basis among members of his staff, Dean Hunsaker declared.

While Dean Hunsaker rather gently outlined the need, objectives and value of continuous and broad adult education, Dr. William A. Irwin, educational director of the American Institute of Banking, presented a more direct challenge.

The A.I.B. has been in the field of adult education for professional preparation since 1900, he declared. In the last peace year, students spent more than 2,500,000 hours in study and classroom work outside of regular working hours. The institute has more than 30,000 graduates and 100,000 other students.

In his rolling Scotch accent, Doctor Irwin also outlined the work of the Gradute School of Banking conducted by the institute at Rutgers College, New Brunswick, N. J. Here, students, not more than 200 new ones a year, enter upon a coordinated program of study. They spend two weeks in residence for each of three successive years and then carry on extension study during the intervening periods. The faculty includes bankers, lawyers, economists and representatives of various fields of business.

After a visit to the American Institute of Banking, extensive reading in the field of adult education and consultation with experts, Ada Belle McCleery, chairman of the A.C.H.A. committee on institutes, came back to Chicago full of enthusiasm about the future opportunities of the college.

"But when I began to present my findings and ideas, my enthusiasm was chilled," she admitted. It was chilled by complacency, a sin of which she said she, too, pleaded guilty.

It was also chilled by looking over the record to see that in four years only 60 persons had advanced from nominee to member and only seven from member to fellow. Furthermore, less than 20 per cent of the students in the institutes conducted by the college have been affiliated with the college.

Then there are certain "chilling" intangibles: unfamiliarity with sources of help outside the hospital field, the discouraging attitude toward study while one is working and, worst of all, the attitude of "Why should I study; I have the confidence of my board."

Various encouraging positive pieces of evidence were also cited by Miss McCleery, among them a keen interest in self-advancement on the part of a few administrators, increasing financial aid to the college for its educational program and various new developments in the educational program of the college.

What is competency in hospital administration? How can competency be measured? These questions were placed before everyone attending the eleventh annual dinner of the American College of Hospital Administrators in the form of two charts showing in diagrammatic form the majority of the problems which present themselves for solution and which are under consideration by the college. Dr. Robert H. Bishop Jr., president of the college, urged that they be studied and an attempt made to answer them in terms of individual needs.

Said Doctor Bishop: "Social and economic changes and the threat to the future growth and leadership of the voluntary hospitals implied in the Wagner Bill emphasize the immediate need for a crystallization of our thinking in the development of a program that will ensure the future of the college as an educational institution. . . ."

It is planned that institutes may be held for members of the college, one on the West Coast, one in the Middle West and one on the East Coast. Announcement is made of such an institute to be held January 22 to 28 with the cooperation of the University of Minnesota similar to the one for fellows held last April under the leadership of Dr. William A. O'Brien.

Other high points resulting from study of educational needs are promotion of organized courses in universities and provision of a textbook in hospital administration.

Joseph G. Norby, president of the college, 1942-1943, received the past president's emblem and Dr. Claude W. Munger, the new president, was introduced. The speaker of the evening was Mrs. Ruth Bryan Owen (Rohde), former ambassador to Denmark.

The college has now agreed on a five point educational policy and work to implement this policy is now going forward under the direction of the officers and a technical specialist in education. It is expected that the college can obtain some outside financial aid to carry on this work.

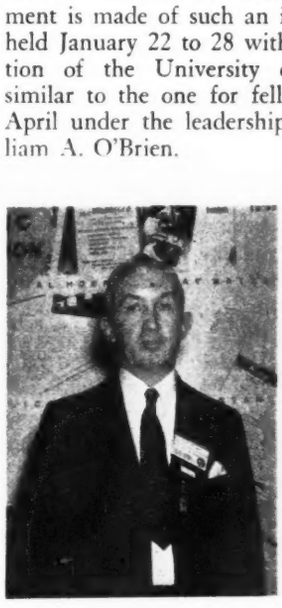
Dr. Robin C. Buerki has been appointed chairman of the educational policies committee to succeed Dr. A. C. Bachmeyer. The members voted to put more emphasis on the code of ethics and see if it cannot be adopted by a larger number of hospitals in the United States and Canada.

Pharmacy

If any hospital pharmacy ever realizes all of the ideals outlined by the speakers at the pharmacy session, the pharmacist will be convinced that he has died and gone to heaven. However, it was emphasized by all of the speakers that there is nothing unobtainable in any of the objectives set forth. All it takes are planning, foresight and cooperation.

Leading off the session, Dean E. R. Serles of the University of Illinois College of Pharmacy discussed the planning of the physical setup of the department.

"In general," he asserted, "the dispensing unit should be on the first floor as near as possible to the reception center. It should be connected by conveyor service to a drug station on each of the floor levels and should also have direct con-



LEFT: William B. Sweeney, Windham Memorial Hospital, Willimantic, Conn. CENTER: H. J. Mohler, Missouri Pacific Hospital Association, St. Louis. RIGHT: Herman Hensel, Presbyterian Hospital, Chicago.

veyor service to the manufacturing unit which may be located either on the same floor, or in suitable space directly beneath the dispensing unit."

Space—for storage, dispensing and manufacturing—is what most pharmacies have the least of, in Dean Serles'opinion. He outlined the amount of space that should be allotted: (1) for receiving raw drug materials, pharmaceuticals and drug sundries in the warehouse; (2) for storing manufactured pharmaceuticals, including a walk-in cooling chamber; (3) for the manufacturing pharmacy, and (4) for dispensing.

The wish that a national hospital formulary might come out of the Cleveland meeting was expressed in a paper by Hazel Landeen, vice chairman of the American Society of Hospital Pharmacists, St. Paul, Minn., which was read in her absence by Dr. Chauncey D. Leake. As a result of Miss Landeen's suggestion, the meeting resolved to request the A.H.A. to form a committee to study the establishment of a national formulary.

The function of formularies was discussed by Doctor Leake, who is dean of the school of medicine of the University of Texas. He described the excellent formulary worked out at the University of California Hospital. This formulary contains two major divisions: (1) a list of drugs carried regularly in the pharmacy, including a statement of the physical makeup, rate of absorption and excretion, chief actions, the forms in which they are available; possible toxic effects and average dosage; (2) therapeutic index, listing the general types of disease conditions and drugs that might be employed in connection with them.

The preparation of the formulary is one of the most valuable services that the pharmacist can render to the hospital, declared Don E. Francke, chief pharmacist at the University of Michigan Hospital, Ann Arbor. "A properly compiled formulary," he stated, "simplifies therapy, aids teaching, educates physicians about drugs that are available and in use, promotes economy and eliminates duplication and waste."

When, how and by whom should the pharmaceutical salesman be given an audience? This question that often causes difficulties and friction was dealt with by Dr. Frank C. Sutton, assistant medical director, Rochester General Hospital, Rochester, N. Y. Doctor Sutton described the plan that has been developed at his hospital which appears to be meeting with the approval of both the administration and the pharmaceutical representatives. In brief, it works as follows:

All sales visits are made to house officers in a group meeting arranged by the assistant medical director. Products to be discussed are limited to those in the U.S.P., N.F. and N.N.R., except for products of merit that have not yet been approved by the American Medical Association. The time for the meetings, which are held to thirty minutes, is selected so as to cause the least possible disruption of the house officers' routine. An advance notice is posted telling of the time of the meeting, and attendance is optional.

Under such an arrangement, the pharmaceutical representative is assured of a fair hearing and the hospital is not disturbed by unauthorized calls.

A concise summing up of the fundamental rules that must be observed in order to bring both pharmacy and pharmacist up to minimum standards was made by Evelyn Gray Scott, chief pharmacist of St. Luke's Hospital, Cleveland.

LEFT: Robert A. Nettleton, Iowa Methodist Hospital, Des Moines.
CENTER: Mrs. Jewell W. Thrasher, Frazier-Ellis Hospital, Dothan, Ala.
RIGHT: C. K. Shiro, Spartanburg General Hospital, Spartanburg, S. C.

Purchasing

Purchasing is one of the problems that is uppermost in the minds of hospital people these days, judging by the tremendous turnout, 839 by actual count, at the purchasing section. The eyes of most of the speakers were turned toward the future — the future of hospital industries, the future of purchasing and the future trend of prices.

The value of standardization and simplification in reducing costs and assuring satisfactory quality was expounded by Neal R. Johnson, purchasing agent of Johns Hopkins Hospital, Baltimore. A number of strictly hospital commodities, such as hypodermic needles, have been standardized by the Simplification and Standardization Committee of the A.H.A. Council on Administrative Practice, Mr. Johnson stated, and superfluous types of these commodities have been eliminated. Work is now progressing on the standardization of surgical instruments, blankets, patients' gowns and surgical dressings.

The meeting unanimously approved a resolution urging the Council on Administrative Practice, the coordinating committee and trustees to approve recommendations of the Standardization and Simplification Committee that a research fellowship be set up by the A.H.A. in the National Bureau of Standards and that this fellowship be under the direct jurisdiction of the S. and S. Committee.

The same careful business methods that are practiced in industry were recommended for hospitals by Guy J. Clark, executive secretary of the Cleveland Hospital Council. Some of the procedures that would put hospital purchasing on a truly business-like basis include a breakdown by departments of the operating cost of the hospital, a reference file of costs of raw food purchased each month and comparison of such costs with those of other hospitals in the community.

Assuming the rôle of prophet, H. N. McGill, president of McGill Commodity Service, Inc., Auburndale, Mass. predicted that the "shock of peace will have a far greater effect on our economy than did the declaration of war."

The underlying trend of industrial activity is unquestionably downward, Mr. McGill stated. However, allowing for a 30 per cent drop after the German defeat and 20 per cent after Japan's defeat, our industrial activity would still be higher than in any peace-time year.

There seems to be a great difference of opinion as to what postwar prices will do, but the speaker asserted that before the postwar boom takes place we must look forward to a difficult adjustment period. In order to maintain a sound supply and price control program, Mr. McGill believes that government surpluses will be released.

Amazing dollar savings can be effected by centralized purchasing, in the opinion of O. G. Sawyer, purchasing agent of Duke University. He believes

that all purchases, repairs, requests for prices, correspondence with supplier, adjustment negotiations and salesmen should be handled through the single channel of the purchasing department.

The Hospital Industries Association was represented by Howard Fish, vice president of American Sterilizer Company, Erie, Pa. Mr. Fish expressed the general optimism that prevails among the manufacturers of hospital equipment that there will be a general lifting, or at least lessening, of restrictions shortly after the defeat of Germany. However, realism demands that civilian purchasers will have to face the fact that it will be many months before supplies of raw material and trained labor will be available to allow new developments for the civilian market.

Exhibits

Throughout the well-planned and attractively set up exhibit hall and, it may be added, among the administrators, there was a spirit of optimism that was in marked contrast to the note of apprehension at last year's meeting.

Many manufacturers were again able to show stainless steel, rubber tired wheels, various sizes and models of equipment and prewar materials in items now available to hospitals even though these advantages are not yet being offered to civilian clients. Nonetheless they admitted that government requirements and manpower shortages prevented them from full production to meet the demands and urgent needs of hospitals. Established and newly developed pharmaceutical products, with particular emphasis on penicillin, its present uses and further possibilities, were a source of constant and interested attention.

Many new items are poking their heads above the horizon although, in some cases, with a certain degree of caution so as not to expose themselves prematurely to competition. They have undergone or are undergoing the research and development stages. They will be ready for announcement and delivery as soon as peace becomes a reality and materials and manpower can be fully released for civilian needs.

One of the new items shown, which will find its full use and development in the postwar era, was an instrument known in laboratories but not yet offered to the public. It gave one the thrill or the disappointment of listening to his own voice magnetized on a wire and played back on the same machine.

The belief of city slum children without benefit of visits to rural communities that milk comes from a bottle is given credence by the machine that produces milk with a fresh country flavor.

An ingenious bed that can be manipulated by the patient into a number of positions and which can be locked in any accepted position for various types of cases by the attending nurse or physician while also serving as a treatment table or a chair was investigated by many visitors and was the subject of considerable discussion.

Saving the time of nurses through making all facilities for patient care immediately available within the private or ward room through sectional prebuilt units was the major theme of another exhibit.

A deodorizing plaster cast and a liquid deodorizer for saturating dressings for suppurating and malodorous wounds seemed like a happy solution to many problems, while the new 70 mm. x-ray films for chest and other examinations and diagnoses were shown for the first time. Also on display was an orthopedic sheath to give the necessary firmness and rigidity to the hospital bed needed for orthopedic cases.

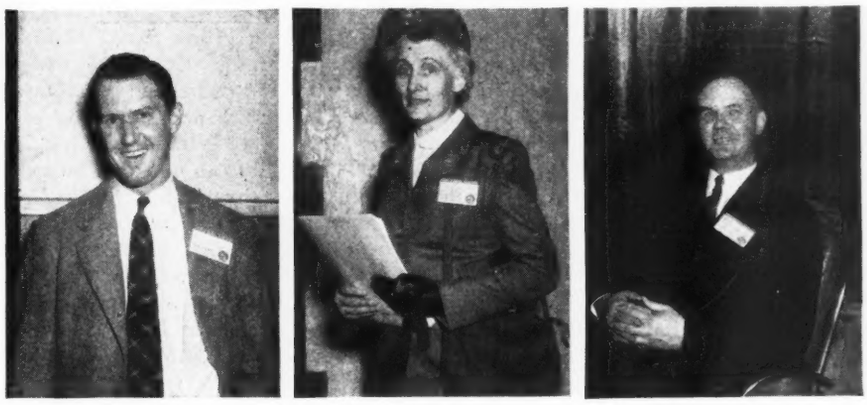
A magnifying light for examination purposes, a simple but practical dispenser for latex tubing and many other equipment and supply items, both large and small, made the exhibit well worth the time and footpower used by the many hospital executives who walked the miles of aisles in the exhibit halls.

It is gratifying that each year sees an increasingly high quality in the educational exhibits. In the main those presented were developed by national associations and federal agencies while local groups also featured interesting displays. But it is unfortunate that too frequently this material is placed in a rather inaccessible location.

While astounding new equipment and supplies items are in the offing, realistic manufacturers recognize that their first responsibility is to meet present urgent needs while giving time to the further development and testing of new products. The inference, therefore, is that hospitals should not sit back and wait but should avail themselves of the first opportunity to replenish inventories with time-tested items and grant the manufacturers ample time for the building and launching of new ships.

Tuberculosis

The general hospital is destined to play an important part in postwar plans for tuberculosis control, according to Dr. J. Winthrop Peabody, professor of diseases of the respiratory system, Georgetown University, and member of the board of directors, National Tuberculosis Association. First, without it there would be no facilities for sanatorial treatment. Second, where sanatoriums do exist they are generally overcrowded. Third, the general hospital provides superior opportunities for early diagnosis and special therapy. Fourth, prompt removal of suspected patients ensures effective prophylaxis in the home. Fifth, public health is safeguarded by the segregation of tuberculous patients.



LEFT: James M. Daniel, Rockingham Memorial Hospital, Harrisonburg, Va. CENTER: Katherine Densford, R.N., University of Minnesota School of Nursing. RIGHT: Dr. L. J. Crozier, Victoria Hospital, London, Ont.

Doctor Peabody and others participating in the discussion, including Dr. H. Stuart Willis, medical director and superintendent, William H. Maybury Sanitarium, Northville, Mich.; Dr. George C. Adie, director of surgery, Grasslands Hospital, Valhalla, N. Y., and consultant in thoracic surgery, Mount Vernon Hospital, Mount Vernon, and St. Agnes Hospital, White Plains, and Dr. Leopold Brahdy, New York City, emphasized the responsibilities of the general hospital in providing proper medical and surgical facilities and safeguarding other patients, employes and visitors from infection.

Recommended protective measures include performing on every girl prior to her acceptance to nursing training a Mantoux test and a radiogram of the chest. Everyone coming in contact with tuberculous patients should be carefully instructed in the technic of aseptic nursing. All should be taught

that physical cleanliness and hygienic practice play an important part in the prevention of infection.

Because tuberculosis is sometimes found in patients and, more rarely, in visitors a radiograph should be made of the chest of every patient who enters the general hospital. Similarly, regular visitors to tuberculous patients should undergo a radiological examination. Children particularly should be safeguarded against tubercle bacilli.

Out-Patients

Hospitals are developing health-maintenance programs which indicate their desire to grow with the health needs of the nation. In the absence of Dr. H. G. Weiskotten, dean, College of Medicine, Syracuse University, Dr. O. W. H. Mitchell of the same institution described the research conducted by students which revealed that the post-hospital medical care of most discharged patients was unsatisfactory. Supervision by the physicians responsible for medical care during hospitalization was discontinued; adverse social and economic factors, inoperative during hospitalization, exerted their influence when the patient was discharged. In consequence, many patients required readmittance to the hospital.

An extramural resident was appointed and given the responsibility for the general supervision of all patients discharged from the medical wards of the University Hospital. Serving as family physician to those patients who had none he followed the progress of others through their physicians. By keeping track of others who were transferred to other institutions and arranging appointments for those who were referred to the dispensary for periodic checkups, an extramural resident fulfills hospitals' responsibility to the community.

In the teaching hospitals and in the great metropolitan centers of the North the place of the out-patient department seems secure. Elsewhere, the future of such services in small community hospitals is not too bright as George W. Eustler, administrator, Holston Valley Community Hospital, Kingsport, Tenn., views it. As for social work he finds little activity worthy of the name in small places and clinic care is necessarily detached from the life situation. The out-patient department is indeed a stepchild.

Speaking further on the subject Mr. Eustler said:

"The device of prepayment which, in one form or another, is incorporated as an essential element of every proposal for distributing comprehensive health services opens vast possibilities of cooperation between public health agencies and hospitals. Prepayment joins with public health, hospital and medical practice as the fourth pillar in the broadened base of partnership comprising the community's organization of total health services."

Whether emergency room treatment given in a hospital shall be covered by Blue Cross hospitalization plans is a question of importance since these accidents and minor illnesses if left untreated might lead to in-patient hospitalization. An analysis of the 77 Blue Cross plans approved at the first of this year, as revealed by Stanley H. Saunders, executive director, Hospital Service Corporation of Rhode Island, shows that 37 do carry a provision for emergency room service and it appears to be in the public interest to provide service for bona fide emergency cases. This practice does not increase total hospitalization expenses; conversely, it has a tendency to avoid a certain number of in-patient admissions and to improve relations with subscribers and their families.

Dr. David P. Barr, physician-in-chief, Society of the New York Hospital and professor, Cornell University Medical School, outlined certain trends in out-patient service, which was followed by discussion led by Dr. Claude W. Munger.

LEFT: Ray Bodwell, Huron Road Hospital, Cleveland. CENTER: Thelma Cheeseman, Vaughan Wright Bendel Clinic, Monroe, La. RIGHT: Whitelaw Hunt, Charleroi-Monessen Hospital, Charleroi, Pa.

Volunteers

"Suffering through the toxemia of pregnancy, breach delivery, precocious childhood and stormy adolescence, volunteer service in the hospital has at last come of age."

The words are Dr. Anthony J. J. Rourke's who gave a case history of the volunteer movement, finding that historically it parallels that of hospital administration.

In the postwar world, reconversion plans must prevent the collapse of the volunteer program. Doctor Rourke suggested three principles to be followed:

1. Volunteers, having obtained a professional level, must raise their sights to new horizons. Hospitals should no longer be financed by tea parties and cake sales.

2. Their leaders must be watchful so as not to be accused of displacing paid workers.

3. To be successful volunteer service must be volunteer from the top down (this does not preclude a paid director).

The Western administrator urged hospitals to keep in contact with their wartime volunteers, many of whom will return after a well-earned vacation. He suggested alumnae meetings of the war groups.

Among new postwar responsibilities Doctor Rourke named interpretation of the hospital to the public and widespread health education activities in the community.

At Massachusetts General Hospital, new volunteers are put on one month's probation at the end of which they can withdraw or be guided into some other volunteer field if they don't like the hospital or the hospital doesn't like them. When the probationary period ends, those who qualify sign a pledge card promising to uphold the standards and traditions of the institution.

Eleanor Greenwood, chief of the volunteer service bureau at M.G.H., thinks that a salaried volunteer director with the status of a regular department head has psychological value. Volunteers like to think they are under a real department head. M.G.H. also has an advisory committee for its volunteer service bureau and the director of the bureau likes to feel that she has this committee standing behind her. The committee is made up of the heads of all departments using volunteers.

A 38 bed hospital in a town of 3500 has 500 volunteers, organized as the Women's Hospital Service League. Mrs. Esther Morris of Allegan, Mich., was at the convention to describe this amazing service, although the Allegan Health Center (a community hospital) did not know the effort was unusual until a traveler discovered the unique setup. The list of the services they render will

LEFT: Hazel Blanchard, Samaritan Hospital, Troy, N. Y.; Alma Webb, Baylor Hospital, Dallas, Tex., and Jessie Compton, Methodist Hospital, Dallas.

RIGHT: Dr. Jose Garcia-Diaz, director, Hospital Department, Venezuela; Dr. Gaudencio Garza, General Hospital, Mexico City, and Dr. Federico Marin, Marin Hermanos Clinic, Mexico City.

be enumerated next month in the Volunteer Activities department of this magazine.

An evaluation of the A.H.A. program for volunteer service was made by Mrs. D. K. Rose of St. Louis and it was a flattering estimate of the work of the committee that set up the standards.

Each year the audience changes at this session of volunteers. At first it was a group of women wearing orchids, then of women knitting for war as they listened to inspirational speeches. This year the audience was one third men administrators, an even larger percentage of women administrators, eight or so directors of volunteers and a handful of volunteers themselves.

The volunteers were at the hospital working on their jobs while the paid personnel and the executives who have been able to keep hospitals operating solely because of volunteer aid were earnestly planning how to manage these unpaid workers more effectively and how to retain the good work of some and the good will of all after the war.

Business Management

An unscheduled feature of the business management section—but a very popular one—was the report by innings on the opening game of the World Series which was given at intervals by the secretary of the meeting, H. S. Mehring, business director of Pennsylvania Hospital, Department of Mental and Nervous Diseases, Philadelphia.

As far as serious business was concerned, attention was focused first on the discussion by Dr. Fred G. Carter, superintendent, St. Luke's Hospital, Cleveland, of "Federal Purchase of Hospital Service."

The federal government, Doctor Carter emphasized, will not pay more than established ward rates and in many cases ward rates are below cost. The hospitals must follow uniform bookkeeping and accounting methods to establish true costs so that the facts can be shown to the federal and state agencies, he said.

Ward rates must be based on costs arrived at by the standard A.H.A. manual of accounting so that all rates, whether general public, local, state or federal, are the same. Doctor Carter illustrated his contention by pointing out the trouble which the Children's Bureau is having in discovering even an approximate cost per day in many hospitals, owing to lack of uniform accounting.

Following Doctor Carter's talk (with time out for the baseball score), a simple, inexpensive punch board by which a hospital can coordinate the revenue from patients and the statistics covering these patients was described by Leslie D. Reid, assistant superintendent, Presbyterian Hospital, Chicago. Each member of the audience was given a card so that all could follow Mr. Reid's explanation of this method of accumulating revenue and statistical information.

More than half of the items listed on the card can be punched on admission of the patient and the remainder, on discharge, so that during the patient's stay some of the information coded is available for statistical purposes.

The practical applications of the card include: such statistics on in-patient days as are accumulated daily; proof of room and board revenue charged, provided this is picked up daily on patients' accounts; study of the areas from which the hospital draws its patients, with revenue received; study of how patients are paying their bills; an analysis of the length of stay.

New rulings of the W.P.B. allowing manufacturers to apply for permission to tool up and prepare for civilian production and the "spot authorization" which actually starts civilian production on the O.K. of the local War Manpower Commission and War Production Board give rise to a situation that can best be described as "engines chugging busily in a boat tied to a military dock."

Thus, Edwin B. George, economist of Dun and Bradstreet, Inc., New York City, phrased the fact that military leaders are still opposed to reconversion to civilian production.

Mr. George stressed the tremendous problems facing the federal agencies in minimizing unemployment in the reconversion period. Most analysts, he stated, think that there will be a sharp rise in unemployment after the end of the German war and another after the Japanese war.

Protestants

Were it not dangerous to oversimplify, one might count hospital chaplains as blessings and cadet nurses as tribulations.

The American Protestant Hospital Association doesn't put these two groups of newcomers into quite such airtight compartments as the foregoing. However, it does preen itself a bit over the progress in the hospital chaplaincy (the hall was dotted with men in clerical garb) and it has encountered certain obstacles in the administration of the cadet nurse corps program. Since the Cleveland meeting, however, the selection and training of chaplains will be done considerably more painstakingly and the cadet nurse program should proceed more easily.

The manners, morals and scruples of the younger generation came in for criticism from some of the administrators present, who complained that in some places, notably Texas, young women are attracted by the recruitment campaign, embark upon their training and then decide that the life of a nurse is not to their liking. Many of these refuse to repay the government stipend despite the fact that they or their parents signed a contract obligating this refund.

David H. Spanier, administrative officer of the Division of Nurse Education, U.S.P.H.S., told the administrators that the general counsel for the government has recently ruled that the contract is moral, not legal, and that the U.S.P.H.S. is helpless to do anything about it.

What are hospitals paying senior cadets? Most of them pay only the $30 required and to the administrators' surprise have lost few students to governmental hospitals that pay higher salaries.



LEFT: Nels E. Hanshus, Luther Hospital, Eau Claire, Wis. CENTER: Benjamin Wright, Cumberland Memorial Hospital, Cumberland, Md. RIGHT: Karl P. Meister, Methodist Board of Hospitals and Homes, Chicago.

Two big hospitals in Dallas pay senior cadets $100 a month and let them live out, the audience was astounded to learn. Baylor, one of the two, deducts $42 a month for maintenance if they live in the hospital.

When it comes to interns and residents, cold comfort came from Dr. Paul Barton of P.&A., who warned the hospitals to get and hang on to as many physically disqualified men as possible. If Bellevue and Strong Memorial can build a complete resident staff of militarily unfit, other hospitals can find some, too, if they will but search them out.

The association's big contribution to hospital thinking is its work on the chaplaincy. Edgar Blake of Wesley Memorial Hospital, Chicago, made some administrators look self-conscious when he mentioned the chaplain's pay. To get the right man he thinks the chaplain should be paid a salary comparable with that paid the pastor of the best church in the city.

Possessed of the right flair, there is no better public relations man than the chaplain, Rev. John G. Martin holds. He can make a satisfied customer of the occasionally disgruntled patient, can make satisfied employes of nurses and can develop interested patrons and benefactors of church people with whom he comes in contact through speeches and sermons.

A vigorous man, not a superannuate, oriented to hospital life through special preparation is E. I. Erickson's choice of chaplain. A hospital can well afford the expense of a postgraduate course for its chaplain, he believes.

Minimum requirements for a clinical internship for theological students have been worked out by Rev. Ralph D. Bonacker of Norton Memorial, Louisville, Ky., who warns against too heavy a teaching load for the theological supervisor in the hospital; four students per supervisor is the maximum load.

The convention listened attentively to the Johns Hopkins plan of a visiting religious staff. The only nonreligious hospital represented on the program, Johns Hopkins has had six years' experience with the plan detailed by Rev. Gordon Pratt Baker. The visiting staff consists of 15 clergymen from six denominations, including a Jewish rabbi.

Lest the association become too concerned with the salary, training and public relations value of the chaplain, Rev. Robert D. Morris of Philadelphia completed the program with case histories of emotional problems that affect hospital patients and how the chaplain can assist physical rehabilitation through spiritual guidance.

Children's Hospitals

One of the most interesting meetings of the convention was the children's hospital section. The well-rounded program kept the delegates long after closing hour.

Discussing postwar planning of children's hospitals, Dr. Robin C. Buerki cautioned against the construction of isolated units, inasmuch as they are not economically sound and cannot possibly provide adequate hospital service. "We have missed developing full potentialities of the children's hospitals," said Doctor Buerki. "Hospitals of less than 200 beds specializing in pediatrics cannot give the service the patient is entitled to."

Edith Baker, director of medical social work of the Children's Bureau in Washington, told the meeting that $8,000,000 has been expended for the care of crippled children. This care is spread over 600 hospitals and represents 2,163,000 days of care purchased by the bureau. Miss Baker described the E.M.I.C. program which takes care of 87 per cent of the enlisted men in the Armed Forces, their wives and infants, to the extent that almost 500,000 patients are being cared for. A review of the methods of reimbursing hospitals under the program in consultation with leading hospital administrators is under consideration.

Mabel Binner, superintendent of Children's Memorial Hospital, Chicago, spoke of the changing times that necessitate adjustment in our thinking and planning. While E.M.I.C. makes it unnecessary for many servicemen to worry about their families, what must happen to the soldier or sailor whose child is over 1 year of age? Should that case be a welfare problem?

One of the most interesting discussions on the program was the responsibility of the children's hospital in the care of rheumatic heart disease. Dr. Albert D. Kaiser, professor of pediatrics, University of Rochester School of Medicine, Rochester, N. Y., told these administrators that they must be more concerned about the care of the child afflicted with this disease. "Between the ages of 10 and 20," said Doctor Kaiser, "it is the leading cause of death. Whooping cough, meningitis, scarlet fever and measles combined contribute fewer deaths than does rheumatic heart disease before age 10."

Winifred Culbertson, superintendent of Children's Convalescent Home, Cincinnati, gave the group new ideas in the teaching of patients. "Health habits and nutrition are all a part of our teaching responsibilities," said Miss Culbertson, "Not only are we teaching centers for doctors and nurses, but we must see that the resident physician, dietitian and others instruct parents and patients in subjects not required in public schools."

The section appointed a committee at the request of the Council on Administrative Practice, to prepare for next year's session and work with the council on children's hospital problems.

Medical Social Service

At least two medical men in the field of hospital administration appreciate the value of the medical social service department as essential to the care of the whole patient and freely admit that far too many of their colleagues still treat this unit like a stepchild instead of according it the rights and privileges of a full-fledged department.

The interest aroused by these expressions and those of the other two speakers at the medical social service session was evidenced by the fact that the audience listened eagerly in spite of the competition from a call bell in the auditorium which punctuated the remarks of all speakers with a cheerful "ding-ding" throughout the entire session.

Dr. E. M. Bluestone, director of Montefiore Hospital for Chronic Diseases,

New York City, would brand into the minds and hearts of all administrators that "social service is the conscience of the hospital." Without it, he stated, the rules and regulations are more rigid and the hospital is less flexible. It is the social worker, he asserted, who stands between the patient and his poverty and she must protect his morale when he appeals for help. Medical social service gives meaning to hospital service and must supplement the cure of the patient or mitigate the physician's failure to effect a cure.

Speaking on medical social service as a form of therapy, Dr. William B. Seymour, assistant director, University Hospitals, Cleveland, pointed out that what the hospital thinks the patient should have and what he wants are often two entirely different things. The reconciliation of this difficulty is a serious problem and one that the medical social worker can do much to solve.

The good social worker can achieve several important goals: (1) she can enable the doctor to temper his prescription to the needs of the individual; (2) she can help the patient carry out the doctor's orders; (3) she can bring to the doctor's attention extraneous factors that influence the patient's recovery.

The points of view of the medical social workers were presented by Mrs. Edith D. Seltzer, medical social consultant, United Hospital Fund, New York City, and Dora Goldstine, assistant professor of medical social work, University of Chicago.

Mrs. Seltzer urged greater sympathy and understanding on the part of both social worker and administrator of each other's problems.

Mrs. Seltzer suggested the extension of social service aid to semiprivate and private patients either on a fee basis or through inclusion in Blue Cross contracts. Social service is needed by many patients in these brackets, she contended, and its extension to them at a moderate charge would place the medical social service department on a clearer and sounder financial basis than it is now.

For several years prior to the war the demand for well-trained medical social workers had exceeded the supply, Miss Goldstine asserted, and since the war the increase in rehabilitation and public health agencies has caused the shortage to become acute. The hospital has always been the logical training ground for medical social workers because it offers supervised experience that makes meaningful the theory they have learned in classroom.

However, the speaker warned, the training program that hospitals will be able to offer in the future will be affected by the extent to which hospitals and doctors recognize the contribution of the medical social worker.

LEFT: Earl Wolff, St. Mary's Hospital, Rochester, Minn. CENTER: Charles Auslander, Michael Reese Hospital, Chicago. RIGHT: T. R. O'Brien, Missouri State Medical Association, St. Louis.

Trustees

Approval of a resolution calling upon the American Hospital Association officially to endorse pensions for all regular hospital employes and to urge member hospitals to take immediate steps to put appropriate pension plans into effect as soon as possible was recommended by John F. McCormack, superintendent, Presbyterian Hospital of the City of New York, speaking before the trustees' section.

"Pension plans tend to stabilize employment and reduce turnover," Mr. McCormack stated. "Qualified persons can look forward with certainty to promotion in position and increase in compensation. And the hospital benefits through direct efforts of ambitious and satisfied employes where work has been rewarded, through the introduction of new ideas and methods they suggest and through their feeling of loyalty and good will.

"There is considerable doubt whether pensions can be accomplished without change in basic business philosophy of hospital management," he went on. "There can be no pension plans unless the financial policy is sound in all respects; hence, the need for a balanced budget. Hospitals cannot give away something for which they receive nothing and yet remain in business. Therefore, the service they give must be paid for in full and the payment must cover all legitimate costs of operation including those of a pension plan. It should also be kept in mind that it is probable that federal legislation will be enacted to bring hospital employes under the provisions of the Social Security Act and this will include pensions."

A committee on pensions was appointed by President Smelzer.

A community trust for hospitals and health activities was advocated by Robert F. Bingham, chairman, board of trustees, Cleveland Hospital Council, and president, board of trustees, St. Luke's Hospital. Mr. Bingham outlined the organization of such trusts as set up in Cleveland and emphasized their value in days of diminishing personal bequests. There is a place for the voluntary hospital in the future picture, he believes, and also for the government supported institution.

Postwar Planning

The optimism that is so characteristically American showed to full advantage in the postwar planning session where hospital, social and economic trends were analyzed before an intent and thoughtful audience.

Some real social planning is under way as work starts in the offices of the new Commission on Hospital Care. Dr. Arthur C. Bachmeyer, director of the study, told the plan of attack. In this collection and compilation of factual data, the state hospital associations will take the initiative.

Some states have anticipated the commission's job and are already at work repairing the deficiencies in medical and hospital care. J. Douglas Coleman was on the program to report Maryland's progress. There the health thinking has advanced through a slow and thorough incubation period to a stage where the legislature will soon consider the use of tax funds for the complete medical care of the indigent and the medically indigent.

Prof. Marshall F. Dimock, discussing social trends in medicine, expressed little sympathy for the doctors who decry socialized medicine. Doctors must become better social scientists, he believes. They must find their own plans for serving the health needs of the people or be willing to cooperate with the government in its schemes. Medicine needs to make a deliberate search for men with executive talents, he asserts, and the prestige attached to administration in the health and hospital field must be increased. In-

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TRUSTEES: Edgar G. Blake Jr., Wesley Memorial Hospital, Chicago; Lawrence R. Payne, Baylor University Hospital, Dallas; Bryce L. Twitty, Hillcrest Memorial Hospital, Tulsa, Okla.; Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark, N. J.

American College of Hospital Administrators

PRESIDENT: Dr. Claude W. Munger, St. Luke's Hospital, New York City.
PRESIDENT-ELECT: Dr. Frank Bradley, Barnes Hospital, St. Louis.
FIRST VICE PRESIDENT: Ada Belle McCleery, Geneva, Ill.
SECOND VICE PRESIDENT: Mrs. Gertrude Folendorf, Shriners Hospital for Crippled Children, San Francisco.
REGENTS: Dr. Claude W. Munger; Dr. James B. Whittington, City Hospital, Winston-Salem, N. C.; Sister Marie Bernard, Sisters of Mercy, Detroit; Dr. Frank Bradley; Dr. George F. Stephens, Royal Victoria Hospital, Montreal.

Hospital Service Plan Commission

CHAIRMAN: John R. Mannix, Chicago.
VICE CHAIRMAN: William S. McNary, Colorado Hospital Service, Denver.
TREASURER: George Putnam, Boston.
DIRECTOR and SECRETARY: C. Rufus Rorem.
COMMISSIONERS: Dr. Lewis E. Jarrett, New Orleans; Msgr. R. Marcellus Wagner, Cincinnati; F. A. Wordenburg, Wilmington, Del.

Hospital Industries Association

PRESIDENT: Elmer H. Noelting, Faultless Caster Corp.
SECRETARY-TREASURER: E. Jack Barnes, Wilson Rubber Co.
DIRECTORS: Charles Pain, Will Ross, Inc., and Howard Fish, American Sterilizer Company.
TRUSTEE: Lawrence Davis, Lewis Manufacturing Co.

creasingly, too, medicine may be required to recruit nonmedical men trained for managerial positions.

Last year's prophet, Dean Herluf V. Olsen of the business school at Dartmouth, returned with more economic forecasts. Assuming that the war with Germany will end in November or December and the war with Japan a year later, Doctor Olsen sees our national income dropping from $158,000,000,000 to $120,000,000,000 through production and employment decline. After a year of adjustment, he expects the national income to rise to $140,000,000,000 or a little higher but not to rise to the war level for quite a time.

For the first two years after the year of adjustment following V-E Day, production will be at capacity producing automobiles and durable goods to satisfy pent-up demands. After that two year period of heavy production it will not be such smooth going. There will be many air pockets. At that time construction must be stressed.

Prophet Olsen does not expect prices to go more than 10 or 15 per cent above the present level. Interest rates will not rise much in the first two years after the war. The atmosphere and environment in which the nation must produce will be stimulating to free enterprise.

Applied to hospitals, he foresees that patients will continue to be able to pay their hospital bills for some time. In regard to buying policies there need be no fear of run-away inflation for a few years. Building commodity prices won't rise much. There will be a greater demand for better hospital and medical services and an even greater need for people of executive ability.

Construction

Two technical discussions that may have been rather over the heads of the audience featured the construction and mechanical section. One of the speakers, Edwin Salmon, chairman of the planning commission of New York City, never arrived at the session. The section was saved by a lively round table led by James A. Hamilton, New Haven Hospital.

The end of the war will make available many new and improved soaps, detergents and antiseptic solutions, according to Jay Harris of Monsanto Chemical Company, Dayton, Ohio. He demonstrated how salt water soaps are soluble in salt water and make good suds. Great improvements have been made in the cleaning ability of soaps and synthetic detergents, he said.

Demonstrations of several interesting new applications of electricity to hospital use were presented by James Stockley of General Electric Company, Schenectady, N. Y. These included a fluorescent light that goes on immediately, a new sun lamp requiring no transformer, a wire recording device for recording speech or dictation, the electronic microscope that magnifies by 20,000 diameters instead of 1500 and a device to measure the intensity of x-rays very accurately.

Personnel

A rather disappointing session on personnel marked the principal attention given to this important subject by the convention. William B. Sweeney, superintendent of the Windham Community Memorial Hospital, Willimantic, Conn., gave his usual fine presentation of a good personnel program for a small hospital —a program that rivals the best of some of our largest institutions. It will shortly be published by the A.H.A. as part of the proceedings of the personnel institute.

But the speaker for the War Manpower Commission, Robert C. Goodwin, indulged in a long discussion of the mechanics of the U.S.E.S. offices without much discussion of how hospitals may best use the facilities. C. C. Bradford, vice president of the Eaton Manufacturing Company of Cleveland, was given the timely subject of "Advisable Wage Policies in View of Present Conditions." He merely outlined, however, the policies of the War Labor Board and then added that hospitals were exempt from these policies.

A good outline of a training program for management personnel was outlined by Joseph Kopäs, director of the department of personnel development, Fenn College, Cleveland. He declared that institutional employe management is spotty and often is mediocre and ineffective. Yet the job of developing management is simple, economical and effective.

No program of developing good personnel management in an institution will be effective unless it is strongly supported by top management. Modern methods of management training should result in: (1) supervision being skilled in getting each worker to do his job correctly, quickly and conscientiously; (2) department heads being helpful in making supervision effective; (3) the institution having a source of skilled workers for upgrading instead of upgrading weakness, and (4) improvement of efficiency and morale.

A lively discussion was led by James W. Stephan of Aultman Hospital, Canton, Ohio.

About People

Administrators

Lt. Col. Basil C. MacLean has been placed on inactive status for the duration, subject to recall by the Army. He has returned to Rochester, N. Y., as director of Strong Memorial Hospital and will also devote part time as head of a 10 member commission requested by Governor Dewey to draft a program providing medical care for the needy of New York State.

J. M. Swain has been made superintendent of Takoma Hospital and Sanitarium, Greeneville, Tenn.

William G. Illinger, for five years administrator of New York State Institute for the Study of Malignant Diseases, Buffalo, has been appointed administrator of White Plains Hospital, White Plains, N. Y. He succeeds **Thomas T. Murray** who has resigned after four years of service.

Robert F. Whitaker, former director of Emory University alumni association, Atlanta, Ga., and assistant to the president of the university, has replaced **Robert S. Hudgens** as superintendent of Emory University Hospital. Mr. Hudgens has become director of hospitals of the Medical College of Virginia at Richmond.

Mrs. I. B. Stafford has resumed her duties as superintendent of Baton Rouge General Hospital, Baton Rouge, La., after a year's illness resulting from an automobile accident.

Gail Squires has been appointed superintendent of St. Luke's Hospital, Davenport, Iowa, upon completion of her internship at St. Barnabas Hospital, Minneapolis.

John F. Barker, superintendent of Dixie Hospital, Hampton, Va., has accepted the position of assistant superintendent of the Gallinger Municipal Hospital, Washington, D. C. **Charles W. Mangum,** business manager and assistant superintendent of Dixie Hospital, will succeed him.

Dr. John H. Law, formerly assistant director of Grace Hospital, Detroit, has been named director of the hospital. He succeeds the late **Dr. E. F. Collins.** Doctor Law is a member of the American College of Hospital Administrators, the Michigan State Hospital Association and the Wayne County Medical Society. He has been active in O.C.D. work as deputy chief of Emergency Medical Services and was recently appointed collaborating recruiting officer of the U. S. Public Health Service for the state of Michigan.

C. Tiffany Loftus has been appointed acting administrator of Arlington Hospital, Arlington, Va., succeeding **Charles H. Dabbs.**

William S. Brines, chief of the hospital section, War Production Board, has resigned to become administrator of Central Maine General Hospital, Lewiston, Me., succeeding the late **Dr. Joelle C. Hiebert.** Mr. Brines takes over his new duties on October 15.

Before going to Washington in February 1943 as senior hospital specialist of W.P.B., Mr. Brines was for three years associate administrator of the House of Mercy Hospital, Pittsfield, Mass. He had been with the hospital and international divisions of Johnson and Johnson and had previously been employed at Rutgers University where he also carried on graduate study.

Mr. Brines is a member of the technical committee of the Federal Board of Hospitalization and the advisory panel of the Civilian Penicillin Distribution Board, is chairman of the hospitals and health committee of W.P.B.'s Community Facilities Program and is an advisory member of the A.H.A. committee on simplification and standardization.

While at the House of Mercy, Mr. Brines was a member of the hospital advisory board of Massachusetts Hospital Service and was chairman of the medical and health committee for Region 1 of the Massachusetts Committee on Public Safety.

Glenn R. Studebaker is acting chief of the hospital section of the War Production Board until a permanent appointment is made to succeed Mr. Brines. Mr. Studebaker, an industrial engineer, was assistant director of Albany Hospital, Albany, N. Y., from 1931 to 1943. He has been with the hospital section of W.P.B. for the last seven months.

Vernon Altvater has resigned as superintendent of Duke Hospital, Duke University, Durham, N. C., to accept an executive position in Washington, D. C., for the duration. **H. C. Mickey,** assistant superintendent at the hospital, has been appointed to succeed him.

Brother Hugh Miller, administrator of Alexian Brothers' Hospital, Chicago, since 1941, has resigned that position because of ill health. He has returned to his old post as pharmacist in the Alexian Brothers' Hospital at Elizabeth, N. J. **Brother Vincent,** formerly of Alexian Brothers' Rest Resort at Signal Mountain, Tenn., succeeds him.

Brother Gerard has succeeded **Brother Basil** as provincial in charge of the entire congregation of Alexian Brothers in the United States.

Department Heads

Margery J. MacLachlan, formerly with the Office of Civilian Defense as hospital consultant and supervisor, has assumed the position of director of nursing service and the school of nursing at Queen's Hospital, Honolulu, Hawaii. **Nora R. Meagher** and **Mrs. Leah K. Da Costa** have been appointed to act as her assistants, and **Yvonee Bost** is the acting educational director.

Mrs. Lorena D. Jones, executive housekeeper of Pennsylvania Hospital, Philadelphia, has resigned to assume a similar position at Baptist Hospitals, Inc., Winston-Salem, N. C. **Mrs. Amy Crawford,** formerly of Columbia Hospital, Wilkinsburg, Pa., has succeeded Mrs. Jones.

Edna N. Witham, R.N., former director of education at Willard Parker Hospital, New York City, was recently appointed director of nursing at Woman's Hospital, New York City. For the last two years Miss Witham has been an instructor in nursing education on the evening sessions staff of Hunter College.

Mabel Mahlman has been appointed director of the school of nursing and superintendent of nurses at Silver Cross Hospital, Joliet, Ill., succeeding **Mrs. Alta Leonard** who recently accepted a position as director of nursing at St. Luke's Hospital, Denver. Miss Mahlman has been educational director and assistant superintendent of nurses at Silver Cross Hospital for the last five years, and her former position will be taken by **Georgia**

(*Continued on page* 146)

An X-Ray Unit Goes Calling

EZRA BRIDGE, M.D.
Superintendent, Iola Sanatorium
Rochester, N. Y.

Lining up for x-ray examinations in Monroe County's mobile unit.

X-RAY examination of between 10,000 and 20,000 persons in Monroe County, New York, during the next year is envisaged with the recent arrival at Iola Sanatorium, Rochester, of a new bus type of ambulatory unit—a complete x-ray laboratory on wheels specially adapted for mass chest examinations.

This mobile x-ray unit, built on a 2 ton truck chassis, was purchased with county tax funds at the direction of the board of supervisors and the sanatorium's board of managers composed of Dr. Floyd S. Winslow, president; Elbert W. Brigham, vice president; Dr. Harvey J. Vary; Tobias Roth, and Elmer A. Raithel.

The unit is to be used in examining the lungs of Monroe County industrial workers and, later, those of high school pupils.

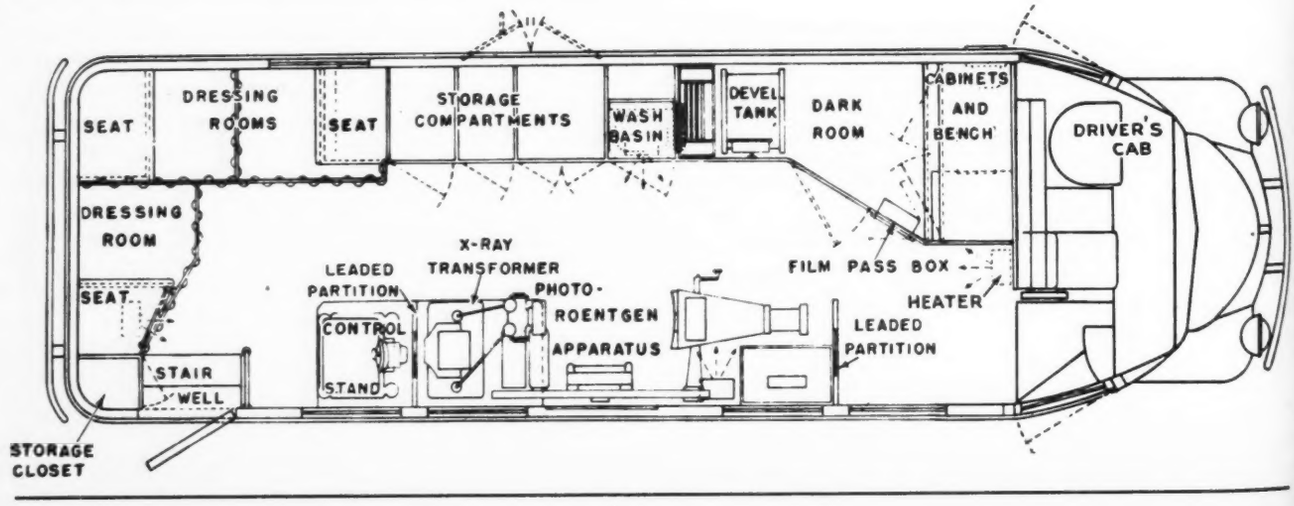
We expect to find from five to seven active cases per thousand. Experience has shown us that at a permanent clinic we can get only 50 per cent of the cases to come for examination; this is because many people are frightened or uncooperative or too busy to submit to x-ray examination. By going to the people we hope to examine from 200 to 250 persons a day with this new outfit. If the x-ray film proves negative, the patient will be given the report. If the film is positive, a report will be sent to the family physician, who will get in touch with the patient.

The blue and white truck is equipped with a photo-roentgen unit, which produces an x-ray image of the chest on a 4 by 5 inch x-ray film instead of on the conventional 14 by 17 film. With this x-ray equipment, which is of the same type as that used in Army induction stations throughout the country, and similar to a unit that we have been using within the sanatorium for more than four years, it is possible to make chest x-ray examinations at the rate of from 45 to 60 per hour.

After our first photo-roentgen unit was installed at Iola Sanatorium, 1000 clinic patients were examined by x-ray twice within three minutes, using full-size film the first time and the 4 by 5 inch film on the second occasion. After the exposures were made and the films processed, the results were compared.

The two roentgenograms of 952, or 95.2 per cent of these cases, were interpreted the same; 48, or 4.8 per cent, had different readings; 43 of these 48 differences were of no importance in respect to finding active cases of tuberculosis.

The group included 259, or 25.9 per cent, cases of significant tuberculosis; two of these cases, only 0.77 per cent, were missed on the small film; of the 130 minimal cases, two, or 1.5 per cent, were missed on the



miniatures. This represents a high degree of efficiency on the part of the small film, assuming conventional radiography to be 100 per cent.

Our conclusions regarding the accuracy of the 4 by 5 photo-roentgen method have been confirmed by various workers in the field of tuberculosis who have published reports of their work in the medical literature during the past three or four years. Incidental to the subject of the mobile unit, but interesting to workers using such equipment, is the high degree of diagnostic perfection to be found in the 4 by 5 stereo pairs, in which the two images are made on a single 4 by 10 film.

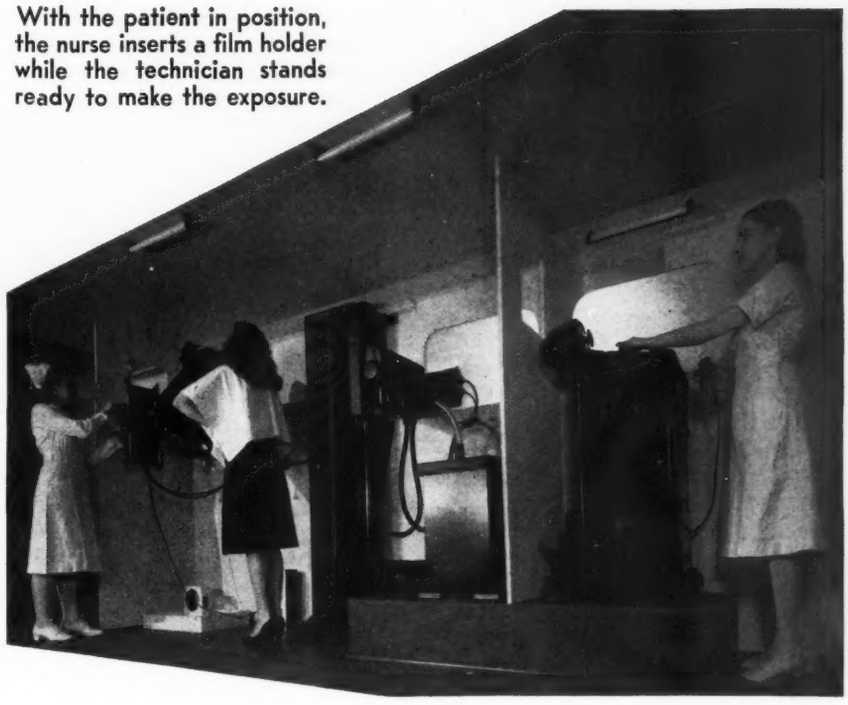
Indications of diagnostic accuracy are a first requisite in the consideration of such a method as that in question, but with that factor established it is possible to look to some of the advantages offered in other directions. For example, the 4 by 5 inch film can be interpreted with less fatigue for the roentgenologist since the area of visual concentration is relatively small. And it is large enough not to require enlargement for interpretative purposes.

The small film also has been found exceedingly useful in the follow-up of discharged patients. Its economy makes possible more frequent examination of all active and inactive cases.

Use of the 4 by 5 film increased the output of our x-ray department about 50 per cent, reduced necessary storage space 65 per cent and decreased material cost about 83 per cent. Development of these small films is simple and obviously uses much less chemical than does a like number of larger films.

From a cost standpoint, the reduction of film size is considered highly important in surveying large groups of people because the expenditure for materials required by the small film method is only about one tenth of that needed for the 14 by 17 conventional film. This means that for a given amount of money to be spent for films and chemicals, 10 times the number of patients can be examined with the 4 by 5 inch films as could with 14 by 17 inch films.

The problem of handling, filing and storing the smaller films is much simpler, too. Technicians have found the 4 by 5 film easier to handle because a holder and two films weigh about 6 ounces while a regular 14 by 17 film holder and film weigh about 10 pounds. The reduced weight naturally facilitates and speeds up examinations.



With the patient in position, the nurse inserts a film holder while the technician stands ready to make the exposure.

The truck is 28½ feet long, 8 feet wide and 9 feet 9 inches high, and weighs about 13,000 pounds. It has three dressing rooms, radiographic room, lead-lined darkroom for the developing of x-ray films and ample cabinet and locker space.

The darkroom has a splashproof developing tank that permits film-processing chemicals to be carried ready for use at any time, wherever the truck stops. A light-tight pass-box permits the passing of loaded film holders into and out of the darkroom without opening the door. Lead-lined partitions protect the operator and x-ray technician against stray radiation.

The truck is fluorescent lighted and has four 1200 watt electric heaters to permit year-around use. Power is supplied through a 150 foot cable carried in a special compartment and connected to the equivalent of a 15 kva. pole transformer supplying 60 cycle current at 200/260 volts.

An unusual feature of our unit is the installation of all x-ray and photo-roentgen apparatus in such a fashion that it can be removed from the bus with relative ease and set up in a large school or factory where the number of people to be examined and the time involved would justify this method of conducting a survey. In general, the survey work will be done in the bus, but we felt it worth while to be prepared to move indoors.

Other features adding to efficiency and convenience, as well as to the comfort of both operators and patients to be examined, include: padded leatherette seats in each of the three dressing rooms; storage compartments under the dressing room seats; weatherproof ventilators in the roof of the vehicle; raising and lowering safety glass windows, with screens; a small hand sink connected to the 35 gallon water storage tank; seats in the driver's cab to accommodate three persons; a film hanger drawer to accommodate 19 film hangers; a cassette storage compartment, and toe space beneath the 46 by 24 inch loading bench.

The same type of x-ray equipment as is installed in this Iola ambulatory unit is used by the Army to examine the chests of draftees. The Army uses the small films for a permanent record to show the individual's chest condition not only at the time of induction, but also at the time of his discharge from service. Thus, it protects the government against unwarranted claims.

In the postwar period, more of these mobile x-ray laboratories should be provided so that many persons, including those in out-of-the-way regions, may benefit by having their lungs examined by modern x-ray methods.

Personnel Is Still a Problem

PERSONNEL shortages in small hospitals either are not as bad as they have been reported or, more probably, are so extremely severe that hospital administrators cannot even take time off to answer a questionnaire about them. At least that would seem to be the conclusion from the fact that only 11 of 50 small hospitals queried on the subject took time out to answer.

Eight of these hospitals reported that they are now experiencing serious shortages of personnel and one other said that the shortage had been "slightly relieved" during recent months.

Nurses Lead All the Rest

The most serious shortage is of general duty nurses, all nine of the hospitals with shortages reporting difficulties on this score. Three mentioned inability to employ cooks and two specified housekeeping maids. One mention was made of each of the following: laundresses, nurse supervisors, surgical nurses, x-ray technician, dietitian, porters, orderlies, secretaries and kitchen help.

The hospitals were asked what steps they have taken to meet the personnel shortage and how successful these have been. Three failed to answer. Five mentioned the training of nurse's aides; one has been fairly successful and one states that the aides are "excellent and efficient."

Other steps reported include the employment of older people and high school pupils, employing nurses by the day and hour, utilizing the services of housekeeping volunteers and increasing salaries as much as the War Labor Board will permit.

Mary Morris, superintendent of Miles Memorial Hospital, Damariscotta, Me., reports that she has "taken all routine steps and has had to call on retired married nurses." This plea for help has had a fairly good response but there are not enough nurses available to keep the hospital properly staffed. The war plants in the area have drawn so heavily on the local womanpower that the hospital cannot compete with them.

A hopeless note is struck by two hospitals, one of which reports sadly: "We have done everything within our knowledge. We have been extraordinarily unsuccessful in finding additional personnel."

The administrator of the other institution states: "We have exhausted all resources of graduate nurses in our community, using older nurses and those who are able to give part-time service. We have several undergraduates who have not completed training for some reason." However, it is this hospital that has found at least one ray of light in the efficiency of its Red Cross nurse's aides.

Newspaper advertising has been the only effective means of finding help for one New England hospital. Placement bureaus and employment agencies have been unable to supply employes at wages that the institution is prepared to pay.

Queried on the amount of help and cooperation that had been obtained from the United States Employment Service, three hospitals report that they have not notified the U.S.E.S. of their needs and one rural hospital explains that there is no agency within 30 miles of the town and that it is impossible to find people who are willing to leave the city to come to the country to work.

Help From the U.S.E.S.

Of those that have asked the help of the U.S.E.S., three report that the agency's cooperation has been at least partially successful. For example, Supt. Georga S. Shanstrom, Larimer County Hospital, Fort Collins, Colo., has obtained some maids and laundry workers through the U.S.E.S. and "it has helped whenever it was able to find workers."

However, the government's venture into the employment agency business has been a decided flop, in the eyes of one hosptal administrator, who states: "Cooperation has been to the extent that it does not have any professional personnel to refer to us and it does not know how to get any for us. It is our opinion that if we had less governmental bureaus, offices and other agencies our personnel problem woud be lifted immediately."

Finally, the question was asked: "What recommendations do you have for general improvement of the

THANKS TO THESE ADMINISTRATORS

HOSPITAL	ADMINISTRATOR	BEDS
Lawrenceburg Hospital, Lawrenceburg, Tenn.	Mrs. Violette Willie	20
Roslyn Cle Elum Beneficial Company Hospital, Cle Elum, Wash.	Patricia Stanfel, R.N.	20
Miles Memorial Hospital, Damariscotta, Me.	Mrs. Mary A. Morris	25
Concordia Hospital, Concordia, Kan.	Mrs. Mildred B. Doty	35
Johnson Memorial Hospital, Stafford Springs, Conn.	Geneva L. Wayland	40
Alamanca General Hospital, Burlington, N. C.	Lelia Ward	42
Helena Hospital, Helena, Ark.	L. E. Carmen	60
Larimer County Hospital, Fort Collins, Colo.	Georga S. Shanstrom, R.N.	60
Alexander Blain Hospital, Detroit	Anne M. Catlin	60
Joseph H. Pratt Diagnostic Hospital, Boston	Frank E. Wing	63
Wheatley Provident Hospital, Kansas City, Mo.	Lon M. Tellman, M.D.	67

hospital personnel situation?" Three of the respondents failed to respond to this one, two, because they are at present having little difficulty with personnel shortages, surprising as it may seem, and the third apparently sees no solution.

The eight who did reply offer various suggestions, with the major emphasis on higher salaries and better working conditions. Here are some of the recommendations:

1. "My only hope is that the importance of civilian hospitals and civilian needs will not be forgotten. If we are to function we must have personnel." (Another administrator added "Amen" to this.)

2. "I recommend that hospitals be permitted to pay salaries as high as the prevailing wage for similar work in factories (which might, of course, be next to impossible; we do not operate on a cost plus basis)."

3. "Release by various governmental agencies of the multitude of nurses, doctors and other professional personnel that they have doing office and administrative duties. We know that they must have them for all of the silly, asinine and ridiculous bulletins, questionnaires and other things sent to us are signed by 'R.N.' and 'M.D.'"

4. "Better salaries, regular and reasonable hours, pleasant working conditions. This is a small town and these people are interested in their hospital. We have just finished a laboratory course, given by the college and sponsored and financed by the hospital, that has met with much enthusiasm. When conditions permit, our employes are allowed time off duty. Then they do not mind the harder times when they come. They have space to rest in the building.

"Most of our key people have been here for many years. This helps to hold things steady when the going gets hard. We have simplified procedures and with the cooperation of all we have managed to give at least safe service and most of the time patients have been satisfied. The community has recognized the local conditions of crowding and less well-prepared nursing care and has helped in every way. I am anticipating a greater shortage in nursing personnel this winter."

5. "Better trained attendants or aides and better supervision."

6. "Higher wages, elimination of broken time, retirement plan."

VOLUNTEER ACTIVITIES

They Mothered It

After half a century, the women's auxiliary of White Plains Hospital, White Plains, N. Y., took time at a luncheon meeting this year to recount what it has done for the institution. As nearly as could be estimated from annual reports, the auxiliary has given the hospital nearly $750,000 in cash and perhaps more than that in intangibles. More important than either of these, however, this auxiliary has another boast. It gave the community the White Plains Hospital itself.

Back in 1894 a group of 22 women obtained a charter and raised the money for the hospital and later became its board of lady managers. In 1911 the name was changed to the women's auxiliary, which now has a membership of 300.

Volunteer Day at M.G.H.

Teas, dinners and evening festivities have become accepted ways of paying tribute to the work of hospital volunteers but it took a pioneer and pioneering institution like Massachusetts General Hospital, Boston, to honor its volunteers with a full day's ceremony, including an address by the governor of the commonwealth, Leverett Saltonstall.

M.G.H. had a Volunteer Day in 1943 and the second observance took place on June 22 of this year. Almost the entire personnel of Massachusetts General and of Massachusetts Eye and Ear Infirmary took part in a program entitled "M.G.H. on Review."

The review took place in Bulfinch Yard with the speakers on the balcony of the Bulfinch Building. The U. S. Port of Boston Coast Guard Band played martial music and a procession of employes in a double column entered the yard, department by department.

It took almost half an hour for the more than 1500 employes to congregate in the center of the yard where they stood under their banners while Dr. N. W. Faxon, the administrator, expressed the sincere appreciation of the hospital for the efforts of all who served it in any way, both in Boston and overseas.

Governor Saltonstall spoke briefly on the importance of a healthy and happy people, the band played the national anthem and then the great mass broke up into numerous small groups which gradually made their way back to their posts of duty.

Sandwiches, coffee and punch were served in the yard to more than 1000 guests, the Coast Guard band giving a concert meanwhile.

The purpose of the observance was threefold: (1) it emphasized the importance of each worker's task in helping maintain the hospital's high standards in these difficult times; (2) it gave the public and even the workers themselves a graphic picture of the great number of people whose efforts are necessary to make a hospital function; (3) it impressed upon the volunteers that they, too, are valued members of the hospital family who must endeavor to repay trust with proficiency.

Sponsors Camping Trips

The women's division of the Hospital for Joint Diseases, New York City, holds monthly teas at which the hospital trustees, volunteers and hospital personnel meet informally. The teas are occasionally enlivened by a musical program or a movie short.

This women's division concerns itself with both the occupational therapy and the social service departments in both of which services volunteers are active participants. In the former department a clinical training course for occupational therapy aides is given.

Important adjuncts to the social service department are the Clothes Cupboard, which provides clothing for poor patients, and the summer camp program. In 1943 the women's division made it possible for 43 children, selected on the basis of physical and emotional health needs, to go to one of the 19 summer camps, in addition to the orthopedic patients, who are handled separately.

Edits News Letter

A news letter to doctors, nurses and employes in the armed forces is the worth-while project being sponsored by the Junior Auxiliary of Paterson General Hospital, Paterson, N. J. The warm response the news letter receives makes the effort involved a genuine pleasure to the young women. The "juniors" have more than a hundred active members in addition to a sizable associate list.

This auxiliary sponsors the hospital blood bank and provides attendants at the various clinics. Another of its many interesting projects is the typing committee which makes copies of the hospital menus and does other routine tasks. Too, the auxiliary presents a gift to every graduating nurse.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Public Relations Starts Within

RAYMOND P. SLOAN

PUBLIC RELATIONS begins with private or personnel relations. You cannot have the one without the other. You must create something within before you can hope to develop interest and support without. And if something is wrong within (which may well happen without our knowledge) we must take steps to correct that situation before we go any further.

Here we have the weakness of much hospital publicity. Suddenly we have need of friends. So without much thought as to whether we have done anything to earn the friendship, we proceed to woo and hope to win. Then, having gained our selfish aims, we revert to type and remain aloof and indifferent as before.

Be Prepared to Follow Through

Any fund raising campaign, for example, that does not start with a critical and conscientious preliminary survey and end with a long-term follow through program is basically unsound. Before starting any kind of a publicity campaign, in fact, we should ask ourselves, "Are we ready to do something about public relations?"

It is the same with personal friendships. If we experience difficulty in making friends, we should analyze ourselves. Do we radiate friendship, good will? Are we ourselves friendly?

It is difficult enough to change our individual thinking and attitudes, but that is simple compared with the problems of analyzing and possibly changing the thinking of the large numbers of diverse temperaments, personalities and tastes that constitute our hospital families. Yet without the right kind of private relations we cannot hope to promote the right kind of public relations.

Now precisely what do we mean by the term "private relations"? Just this—loyalty, interest, the proper concepts of voluntary hospital service on the part of every individual engaged directly or indirectly in the work. If the hospital family—those who know or should know us best—is not enthusiastic and loyal, what can we hope to gain by employing some professional voice to speak in our behalf?

No, the first step in any public relations program should be to make every hospital worker, from the trustee down to the humblest laundryman, a salesman for the institution, one who will help sell it to the community. For you can sell the hospital when standing by the elevator control, with a mop in your hand, from the switchboard, from every operating position throughout the building, in fact.

Much of the responsibility for creating the proper attitude within rests with the trustees. For, assuming that these men and women represent community leadership, they should set the pitch of public opinion. Are they firmly convinced of the worth of the institution? Are they ready to work diligently and with vision to help the hospital achieve its goals? Unfortunately, their voices have not always been raised as effectively on behalf of voluntary hospitals as they might. They are becoming more audible, however, and more will be heard from them in the postwar period.

There is the question of the medical staff, a perplexing one frequently. What is its attitude toward the hospital? Are these men good salesmen for the institution with which they are identified, their workshop, in fact? Or are they fair weather friends ready to listen to and condone any unjust criticism? If they are not loyal, why not? Is it their fault or the fault of the hospital? What can be done to rectify the conditions? Has someone the courage to face medical staff problems realistically, with due emphasis upon modern trends and the development of the hospital as a true health and medical center?

We don't have to be reminded of the importance of an enthusiastic and interested nursing staff. Except for the food which it is served, the public judges the hospital principally by the quality of its nursing care. Because of the intimate relations that exist between patient and nurse many choice bits of information, some true and some false, are passing along which sooner or later reach the ears of the community. Are your nurses talking for or against your hospital?

Then there is the vast army of departmental employes who may or may not come in contact with the patient and the public. You can tell from the very expression on the face of a worker whether he is happy in his work, satisfied with his job. Too, these workers have families and friends in the community to whom they talk, either for or against the hospital.

How Can We Influence Them?

We might go on and on but these facts are too clearly recognized to need further emphasis. The question is, what can we do with our hospital family to influence its attitudes for rather than against?

We shall start again with the trustee for in him lies much of our hope. He should be posted intelligently on hospital affairs, so that he is prepared to answer questions that may be put to him and interested enough to find out the answers if he doesn't already know them.

Few of us get time to read as much as we should and the trustee is no exception. He will read, nevertheless, certain articles abstracted for

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From a talk delivered before the Institute on Hospital Public Relations sponsored by the Hospital Association of Pennsylvania in cooperation with the extension services of Pennsylvania State College, August 1944.

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Giving an "I.V." can be one of the most routine performances in the hospital — or cause for many a well-deserved tantrum! It all depends on the efficiency of your solution equipment.

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his particular consumption when called to his attention.

At the same time he should be acquainted with the functions of the various hospital departments and with those in charge. It would be illuminating for him to arrange with the administrator to drop in informally at the noon hour and sit at the luncheon table with these department heads.

The relationship that exists between the trustee and the medical staff has much to do with the attitude of the latter. It means much to the doctor to feel that he has behind him a group that is intelligently informed and vitally interested in community health. In addition to the committee of doctors that we assume meets regularly with the board, there should be social gatherings of the two groups so that the doctors will know these men who are the policy-makers of their workshop and the trustees, in turn, will know their doctors. This seems obvious yet it would not be difficult to enumerate hospital after hospital whose board members have never met some of the men who are serving on their medical staffs.

Investigations into the living and working conditions of the nurses, their rooms, their food, their recreational facilities, the character of the individual in charge may reveal cause for discontent. Such conditions should be rectified at once. What is there in life, after all, for a nurse who after a tough day must return to a cell of a room—drab, dreary, colorless—and day after day must eat unappetizing meals in a noisy, dismal basement dining hall? It is so simple to inject a bit of color into her surroundings, also to provide some variety at least in the food served to her.

There is no need to emphasize the growing attention that is being given to hospital personnel problems as manifested by the institute on personnel relations which the American Hospital Association sponsored early in the summer at New Haven. This movement has only begun. Better salaries, better living conditions, training programs, recreational facilities, pension plans—the hospital employe will have something to talk about enthusiastically when he leaves his work each day.

We have much to accomplish to overcome the reputation that hospitals have gained through the years. It is common knowledge that hospitals are at the bottom of the list of practically every placement bureau. Inadequate pay, long hours, bad working and living conditions—not very flattering, to be sure, and not particularly conducive to good public relations.

If every trustee, every staff member, every employe is going to be a salesman for the hospital he must be proud of its physical appearance. Furthermore, his opinion must be shared by the public that enters. This means a building that is attractively furnished and well maintained. It has been said that friends are made or lost at the front door, that the first impression is what counts. True, but we should go further and see that these good impressions carry throughout the entire plant.

Don't be misled into believing that a public relations expert can make up for all that is lacking. No matter how gifted and ingenious he may be, he cannot perform miracles. The most glowing accounts of hospital work will fall upon deaf ears if there is nothing to back them. You can't fool the public for long.

For this reason it is earnestly recommended that the public relations counsel or adviser should think always in terms of private or personal relations. This doesn't mean that he should be a personnel manager but that he should maintain close contacts with the hospital family.

His efforts should receive the full cooperation of the trustees. Where possible he should help to provide them with material to keep them informed on hospital work within and without their own institution.

Friendly relations with the doctors likewise are essential. By nature and profession "publicity shy," they must be shown how the presentation of certain facts based on their research and practice will contribute to public health knowledge. They must know, too, that this can be handled in a thoroughly dignified and ethical manner.

The same applies to the nursing staff and to every other department of the hospital. The public relations head should have as partners in his endeavors all those employed in the institution. They should know what he is attempting to accomplish and lend every cooperation toward that end. What use are elaborate bulletins, brochures and reports if the visitor is met with discourtesy at the front desk or other shortcomings are manifest?

In other words, to achieve public relations, real public relations that is, you must work from within—out.

Pertinent Paragraphs

The People Decide

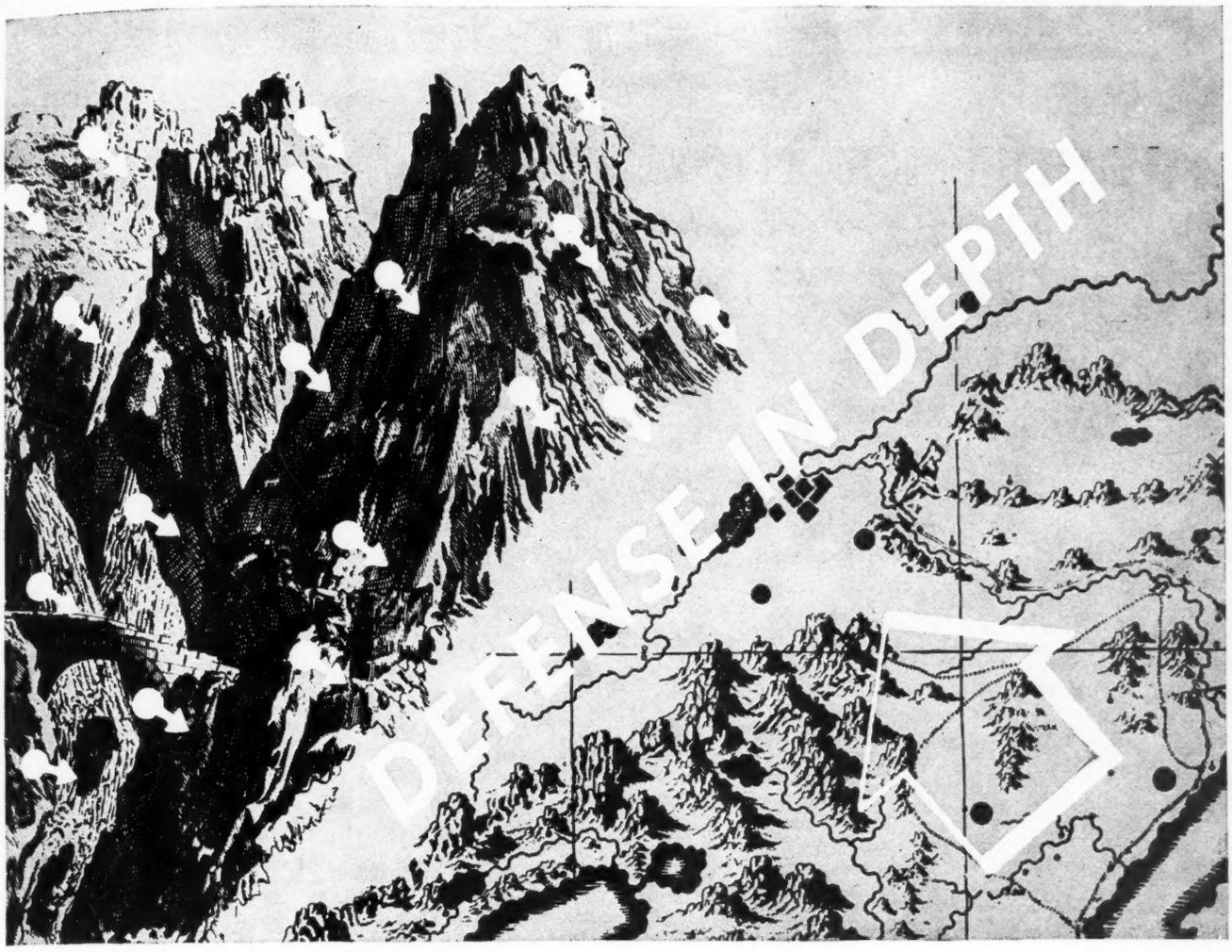
How well you know that a vote of approval by the people in your community for the services you perform can make the job of hospital executives and board members an easier and smoother one. Conversely, an adverse appraisal by the public can result eventually in almost any institution's being voted out of existence. When people are dissatisfied they have a way of showing it. In the case of a business firm, they shop elsewhere. In the case of a hospital, they withhold their support.—H. D. Read, *vice president, Opinion Research Corporation, Princeton, N. J.*

One Rule for All

"Hard cases make bad law." The governing authorities and the administration of the hospital should bear this axiom in mind when they promulgate or interpret policies, rules and regulations.

A ruling that is motivated impulsively in favor of a dissident individual, based on sympathy only, creates a precedent for the future.

This should be borne in mind, unless the hospital authorities are able to maintain at all times an ideal policy of complete individualization.—Henry L. Moses, *president, Montefiore Hospital, New York City.*



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FINE PHARMACEUTICALS SINCE 1886

ANOTHER WAY TO SAVE LIVES — BUY WAR BONDS FOR VICTORY

Support for the Pharmacy *must start at the top*

VAN C. ADAMS
Superintendent, Jewish Hospital, Cincinnati

I CAN speak only for myself but I wager there were many other hospital administrators who, after reading the article entitled "Perhaps It's Your Own Fault" in the November 1943 issue of The MODERN HOSPITAL, sat down and wrote Florence King a congratulatory letter. Here, finally, was an outspoken appraisal of the hospital pharmacist and his pharmacy such as should put an end to a seemingly endless discussion. The pharmacist was advised to stop annoying others with his claims to glory, his tales of persecution, and to get busy and show by accomplishment what he could do for the hospital.

I was left with the feeling that the administrator's responsibility for the development of a better pharmacy program was over. He could now dismiss his concern over the known inadequacies and with complete detachment sit back and wait for the day when, by some official proclamation, it would be announced that through molecular manipulation all hospital pharmacists had been declared perfect. He could, meanwhile, with even greater impunity, haggle with his present pharmacist over a five dollar raise and send him shamefully scurrying back to his basement stall.

It Was Just Wishful Thinking

Before any of my readers whispers it, let me acknowledge that this interpretation of the article was a defense mechanism at work. Ready to admit an awareness that the pharmacy was not all that it could well be in the hospital scheme, I welcomed a transfer of the responsibility for this weakness to someone else.

A more careful reading of Miss King's article discloses, however, that challenging the pharmacist alone was far from her intention. She called for the cooperation of all departments and the medical staff if the pharmacist's potential contribution to the hospital was to be realized. In particular, she cited those administrators who have been guilty of selecting their pharmacists on the basis of strength of back.

Exaggeration and overstatement are handy figures of speech but they should not be required to achieve action and progress in hospital administration—a field in which the members pride themselves upon their scientific zeal and progressiveness. Yet it must be admitted that, in general, administrators have not seen the potentialities in the programs designed to develop the pharmacist for greater responsibilities.

My task is to determine whether this view is short-sighted and unenlightened. In answering the indictment of hospital administrators, which Miss King's article only mildy makes in comparison with many other articles, I realized that my first obligation was to restudy the literature with a more open mind and with the realization that I must come out of this study prepared to assume a positive attitude toward the problems of the pharmacy.

My first conclusion from this new study is that we are all experiencing difficulty in determining and accepting workable standards and this fact has retarded our development. Dr. Fred Carter in a paper on medical records, presented at the American College of Surgeons meeting in Cincinnati last March, referred back to a previous writing in which he had this to say, in part, of standards:

"Standards are those things which are established by duly constituted authority as fixed rules or measures or yardsticks. They may be fixed by law, by custom or tradition, by administrative regulation, by voluntary submission or by public opinion. We recognize in all these the force of duly constituted authority, even though that authority is legal in only the one instance.

"To be of value, standards must be attainable. They must be easily recognized and tested in order to simplify the process of inspection through which they are made effective. The standardization process must aim to preserve what is good in what we have but its very aims will be defeated if it does not also aim to improve what we preserve, thus assuring progress within each standard. Standardization is after all only purposeful, anticipatory thinking—a process of establishing in our imagination pictures of what we would like some day to do, or be or have."

Pharmacy Code Relatively New

We recognize at once that until recently we looked only to public opinion and the federal laws for any guide. Only since 1937 when the American College of Surgeons established a pharmacy code have we gained assistance through voluntary submission on the part of our members. Applying these criteria to our problem I think we encounter the following difficulties:

Differences in size, types (as regards teaching interest) and financial means of various hospitals seem to make for greater difficulty in establishing goals here than in any other adjunct hospital service.

To be of value standards must be attainable and easily recognized. Right here I think we hit upon a snag. Most administrators have probably seen the goals but they could not see the means of attaining them. Their reasons for discouragement were as follows:

Presented at the Ohio Society of Hospital Pharmacists meeting, 1944.

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Softens convulsions thereby preventing trauma in convulsive therapy. Temporarily eliminates spastic paralysis. Used in diagnosing myasthenia gravis.

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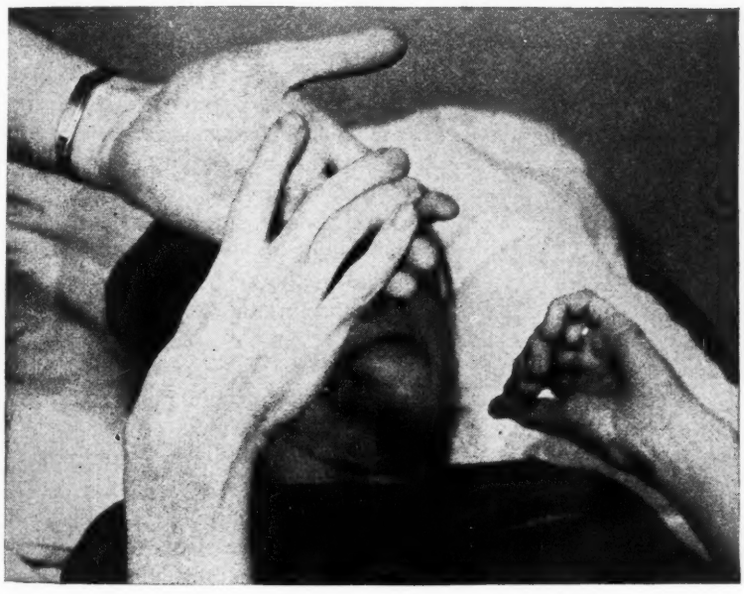
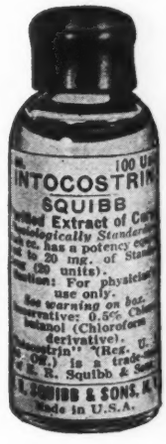
Characteristic athetoid movement. Right hand normal.



Same patient. Hands relaxed after Intocostrin administration.



More than 100,000 injections of Intocostrin have been given. A very clear appraisal has been made of the remarkably uniform response obtained on its administration to human beings . . . Supplied in 5-cc. rubber-capped vials, containing the equivalent of 100 mg. of standard curare; more than sufficient for one injection.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

1. Many hospitals had no pharmacist and, seeing no possible chance of employing one, never thought twice about pharmacy standards.

2. Many hospitals with pharmacists did not consider them qualified and so, once again, the sponge was thrown in.

3. Medical staffs as a whole were apathetic and unless some strong individual wanted to make a lone fight for the proper dispensing of drugs there was no support from the medical profession.

As Doctor Carter pointed out in his paper on the records department, that department and several other adjunct diagnostic and therapeutic services suffer as compared with the more active services, such as surgery and x-ray, because their activities do not lend themselves to the careful scrutiny of the entire medical staff. And perhaps also the physician has not discovered as readily as the pharmacist has the hazards to the patient's welfare under an inadequate pharmacy. All these factors have made it difficult for the administrator to develop a better program.

So much for the difficulties that seem to have paced our development. Have these deterring factors been sufficiently overcome so that with the enthusiasm of such organized groups as the American Society of Hospital Pharmacists we can now make greater strides? Let us study the outlook as we glance at the code of the American College of Surgeons.

No Pharmacist in Many Hospitals

Recent surveys still show a surprising number of sizable hospitals that employ neither a full-time nor part-time pharmacist. Several writers have urged the pharmacist to prepare himself in allied fields, such as clinical laboratory and hospital administration and, especially, purchasing. I believe this to be a most worthwhile proposal. Educators suggest this training as part of a fifth year and certainly these smaller hospitals should welcome this support in these other fields as readily as in their pharmacy.

The code states that the hospital shall appoint a pharmacy committee that shall determine policy, establish and maintain a formulary and supervise purchasing. A drug policy and a formulary—the heart of a pharmacy program as we have been taught—arise only from the culled contributions of these selected committee members. But isn't it the extreme in wishful thinking to believe that many hospitals can muster a handful of physicians at this late date willing to make a stand against the forces of proprietary drugs? I do not believe the average hospital can expect much committee support and, in lieu of this, the pharmacist must be strong enough to direct his own policy and maintain limited controls single-handed.

Certainly, every pharmacy can and should maintain a good reference library. In general, the suggested items are only the tools and armamentarium essential for safety and good practice. A few additional publications are listed for the purpose of stimulating interest on the part of the medical staff, interns and residents and nurses.

In this first code nothing is said as to what encouragement or guidance the pharmacist shall be qualified to give in promoting usage of this reference library. For these seven intervening years, at least, the deans of pharmacy schools have been endeavoring to show us that their curriculums combine full courses in the basic sciences with the purely technical courses of their field as does every established scientific training.

Certainly, we have use for such training in our nursing schools and yet the development of such a program has not been generally seen as a desirable goal. The National League of Nursing Education does not, to my knowledge, recognize the graduate pharmacist as the person best qualified to teach pharmacology and materia medica.

On the contrary, many schools fail even to apprise the pharmacist of what theories and practices are taught so that so far from being able to correlate the pharmacy practices with the teaching, and thus be helpful to the student, he is handicapped and often made to appear individualistic to say the least.

Our neighbor, Bethesda Hospital School of Nursing, Cincinnati, is apparently among the pioneers in developing a correlated program that looks to the pharmacy to supply that portion of the curriculum which is in the province of pharmacy. A full account is given in an article by Hannah Cramer, chief pharmacist, in the *American Professional Pharmacist* for November 1943.

The plan involves two weeks in the pharmacy for each student where a great deal of ground appears to be profitably covered. This school feels that the student thus obtains the proper conception of the importance of drugs and absorbs the pharmacist's passion for exactitude. Whether all hospitals would find this exact program practical for them need not be debated; certainly, the educational principle involved is right.

We lay administrators cannot evaluate the statement that materia medica is no longer adequately taught in medical schools and certainly it would be presumptuous to take up this burden. But it is well within our province to encourage the pharmacist in establishing himself with the medical and nursing professions as an authoritative educational source. A well-furnished and maintained reference library to this end is all that is requested at this time.

Items four and five of the code dealing with standards for drugs and supervision appear to be acceptable to all. One wonders, however, why the term "ethical" does not appear in the formal code inasmuch as the college uses it generally elsewhere and the public has confused ideas about the term as it applies to commercial practices.

The Pharmacist and Public Health

Dr. William A. Jarett, dean of the college of pharmacy, Creighton University, Omaha, has pointed out that the hospital pharmacist can render a great service by leading his profession in helping to formulate the changing social and economic thinking brought about by governmental interest in public health. Inasmuch as the promotion of public health has long been an accepted hospital function, is it not in order to expect from this group as a public service a further clarification of the term "ethical" as it applies to commercial drugs and practices?

In thus reviewing our progress under the American College of Surgeons code we see what limited concepts we hold. Higher educational standards have fully qualified the pharmacy graduate. Is there therefore any reason why this greater pharmacy program should not have our enthusiastic support? I think not.

First of all, hospital administration has got to realize that these men and

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Parenterally or orally administered, this therapeutic agent is of value in hypoproteinemic states, in checking weight loss in wasting diseases, in shortening convalescence after surgery, in speeding the healing of burns and wounds.

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women cannot invest in education at this level, and possibly an internship, and then work for present hospital salaries. Actually, there is little option for us as the registered pharmacist of limited educational background is fast disappearing and other branches of pharmacy bid higher for the limited number of yearly graduates.

Our indifference will be costly if we fail now to give utmost cooperation to the development of a wider hospital pharmacy service.

Hospital Pharmacists Study Ways of "Selling" Value of Good Pharmacy Service

By ALDEN B. MILLS

The most important problems facing the American Society of Hospital Pharmacists are (1) its relations with the American Hospital Association, (2) the development of more and stronger local and regional groups, (3) the study of the place of the hospital pharmacist in group medical care and prepayment plans, (4) the development of standards for hospital pharmacy internships and (5) the improvement of the society's *Bulletin* and other methods of keeping the members in close touch with each other.

These problems were placed before the 125 or more hospital pharmacists who attended the second annual meeting of the society in Cleveland on September 7 and 8 by the chairman, Don E. Francke, chief pharmacist, University of Michigan Hospitals, Ann Arbor.

Cooperate With A.H.A.

"One of our most important jobs," said Mr. Francke, "is to sell the hospital administrator on the value of good pharmacy service in his hospital. One way to do this would be to cooperate effectively with the expanded program of the American Hospital Association by providing the latter with information on the architectural planning of hospital pharmacies, on the products that could properly be manufactured in hospital pharmacies of various sizes, on the personnel required for hospitals of different bed capacities and various out-patient services, on proper levels of compensation for hospital pharmacists and on similar subjects on which we should possess expert information." Mr. Francke recommended that the A.S.H.P. send a strong delegation to the Cleveland convention of the American Hospital Association.

He outlined many advantages to the hospital pharmacist that would result from the development of strong local and regional associations that can meet frequently, provide a quick interchange of information, enable all pharmacists to take an active part in society activities and help them to render the best service to their hospitals. "Your salary is predicated upon the way in which your department is run," he told the pharmacists.

Predicting that some form of nearly universal prepayment plan will be evolved in the next few years and that it may very well be tied up with an increase in group medical practice, Mr. Francke prophesied that this will mean a substantial increase in the importance of hospital pharmacy.

Although the A.S.H.P. voted last year to recommend a one year hospital internship for pharmacists in hospitals approved by the A.C.S. and approved for internships or residencies by the A.M.A., no committee was appointed to work on this subject because of the many uncertainties that the year brought forth and because the members were excessively busy. The chairman recommended that this matter now be taken up and carried forward.

The total membership of the society was reported to be 291, a net gain for the year of 104 members. The constitution is to be changed to permit associate memberships on the part of people who are interested in the field but do not qualify for active membership.

Because of a mixup on the election procedure at previous meetings, it was voted that the present officers should continue in office until the close of the next convention. New officers were nominated and will be voted upon by mail. Present officers, in addition to Mr. Francke, are: vice chairman, Hazel E. Landeen, Mounds Park Hospital, St. Paul; secretary, I. Thomas Reamer, Duke University Hospital, Durham, N. C., and treasurer, Sister Mary John, Mercy Hospital, Toledo, Ohio.

It is vitally important that pharmacists recognize that each hospital is different and that there are wide differences between truly charitable hospitals and profit-making hospitals, Edward Spease of the National Association of Retail Druggists told the convention. In spite of this fact, however, he declared that the hospital was the outstanding place in which to practice true professional pharmacy.

A recent survey of pharmacy practice was criticized by Ivor Griffith, president of the A.Ph.A., because it omitted all pharmacy work in hospitals, thus badly distorting the total community picture.

A comprehensive and able review of the trends in modern medicinals for the last year was made by Dr. Madeline O. Holland, of the *American Professional Pharmacist*. She noted striking advances in therapeutics, especially chemotherapy, and in pharmacy knowledge and practice and a lessened rate of advance of vitamin therapy.

The first objective of the A.S.H.P. should be to make good pharmaceutical service available to all hospitals, according to Glenn L. Jenkins, dean, Purdue University College of Pharmacy. "About one third of the hospitals of the United States have no pharmacist," he stated. "The next objective should be to extend membership to practically all hospital pharmacists. A third should be to bring all pharmacy service in hospitals under the control of registered competent pharmacists."

A critical and careful evaluation of the textbooks for teaching pharmacology to student nurses was prepared by Sister M. Ludmilla but read in her absence. It will appear in a future issue of The Modern Hospital.

Metric System Preferred

The medical and health groups constitute a minority of those who have large stakes in the universal use of the metric system but they act as a powerful spearhead in spreading its adoption, reported Daniel O. McClusky of South Highlands Infirmary, Birmingham, Ala. The movement grows larger as it moves along and now only the United States and the British Commonwealth adhere to other systems. Several hospitals reported that they have adopted the metric system exclusively but they find that the older physicians fight against it.

The election of officers is to be held by mail from among the following candidates:

Chairman: H. O. Hanson, Grant Hospital, Chicago; H. P. Lauve, Charity Hospital, New Orleans, and Hazel Landeen, Mounds Park Hospital, St. Paul.

Vice Chairman: Jennie M. Banning, Bradford Hospital, Bradford, Pa., and Estelle Kiszoans, West Jersey Homeopathic Hospital, Camden, N. J.

Secretary: Walter Frazier, Springfield City Hospital, Springfield, Ohio, and Leo Godley, Norfolk General Hospital, Norfolk, Va.

Treasurer: Sister Gladys, Milwaukee Hospital, Milwaukee, and Sister Teresa, St. Anthony's Hospital, Oklahoma City, Okla.

Chemotherapy of Tuberculosis

FREDERICK F. YONKMAN, M.D.

Department of Pharmacology and Therapeutics
Wayne University, Detroit

TUBERCULOSIS is one of the oldest diseases afflicting mankind and ranks in severity with some of our most incapacitating and lethal diseases which include among others cardio-renal disease, cancer and diabetes.

Many forms of treatment have been recommended for the arrest of tuberculosis, especially that of the pulmonary type. These include absolute bed rest, a well-balanced diet of high caloric value and numerous forms of long since discarded medications which numbered among them such relics as creosote and guaiacol in some form or another. Some physicians even recommended nonstrenuous employment in tar-roofing gangs so that adequate inhalation of "tar fumes" might be assured.

More recently, surgical procedures were introduced with the intent of placing at almost complete rest the affected portions of the lung involved. These procedures included any reasonable technic by which the diaphragm might be immobilized or splintered. At first the phrenic nerve was injected with alcohol or procaine, or it was transected or crushed so as to interfere with neural transmission of nerve impulses controlling the diaphragm. This procedure was accompanied, as a rule, by partial or complete collapse of the affected lung which was produced by insertion of known volumes of sterile air commensurate with the degree of collapse desired, as determined by the fluoroscopic or x-ray technic.

Since phrenic nerve damage and lung collapse were frequently insufficient to assure the desired effect, more extensive surgery was resorted to in the form of releasing pleural adhesions through rib resected portals in the chest wall. Such adhesions usually were responsible for failure of lung collapse even though the associated diaphragmatic leaf had been satisfactorily splintered by divorcing it of its neural control through phrenic nerve sectioning and despite the fact that air had been inserted into the thorax.

Somewhat later, air was introduced under pressure into the peritoneal cavity in order to force the diaphragm higher up into the thoracic cage. This procedure proved to be an efficacious adjunct to existing forms of therapy but it, too, was not without its hazards. Recently, Rilance and Warring of Connecticut have recommended on the basis of their study of 101 patients so treated that the routine use of pneumoperitoneum would not seem to be desirable because the incidence of acute appendicitis in these patients thus treated was 11 times greater than in other sanatorium patients. The cause of such a complication has not been determined but its incidence in this series connotes genuine caution in selection of the use of pneumoperitoneum as a subsidiary form of therapy in this disease.

With the successful advent of sulfa drug therapy in many of our common infections it was only reasonable to anticipate the trial of several such commonly employed sulfa derivatives in tuberculosis. *In vitro* studies were soon followed by attempts to arrest or cure experimental tuberculosis in guinea pigs and clinical tuberculosis in man. The latter attempts were fraught with the most disheartening results.

However, the sulfone radicle has been more recently modified into several forms, each of which, when promising *in vitro*, was tested in the tuberculous guinea pig and man. Among these latter agents one encounters promin (P,P′-diaminodiphenylsulfone-N,N′-didextrose sulfonate) and diasone (disodium formaldehyde sulfoxylate diaminodiphenylsulfone). Both of these synthetic compounds were primarily employed in experimental tuberculosis in guinea pigs and the results of these investigations were sufficiently promising to warrant their employment in the treatment of tuberculosis in man.

Promin was studied chiefly by Hinshaw, Pfuetze and Feldman, and diasone by Petter and Prenzlan. The results of both studies are indeed promising but the limitations of this type of compound, as well as the hopes entertained for it, are well gained from the published results of the latter authors' studies (Amer. Rev. Tuberculosis **49:** 308, 1944, April).

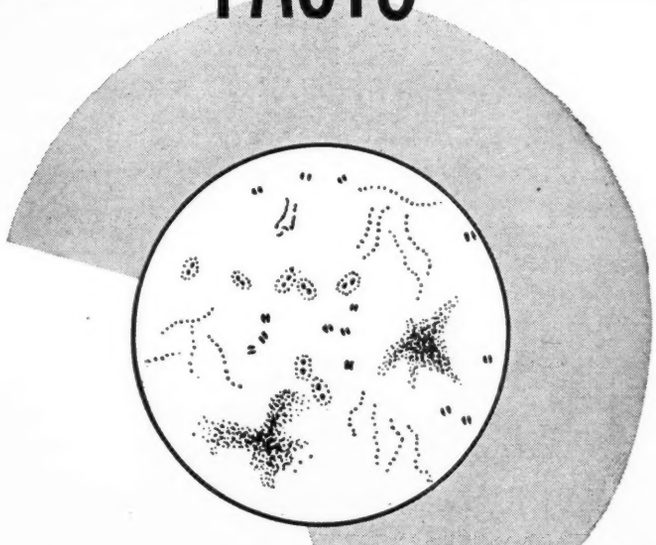
Pertinent points cited by them include:

1. The drug should be administered orally with meals in a total daily dose of one gram for a period of at least 120 days unless serious toxic symptoms interfere.
2. Such treatment has resulted in striking results in some cases.
3. Greatest improvement occurred in the first two or three months of therapy but improvement continued thence, even though less markedly.
4. Chemotherapy replaced, in some instances, enforced bed rest and various forms of collapse measures, with no regrets on the part of the authors.
5. Bronchogenic dissemination has not occurred during this type and period of chemotherapy.
6. At least two patients of the series owe their lives to the chemical and six others were sufficiently improved to permit thoracoplasty.
7. Tuberculosis located elsewhere than in the lungs responded very favorably.
8. Two diabetic patients in this series tolerated the drug well.
9. Enthusiasm regarding the drug must be held in reasonable bounds because of the unpredictable nature of tuberculosis. Changes may be due to other than drug effects. The chemical is still experimental and should be under the strict control of competent physicians who have ready access to adequate laboratory facilities.

Diasone seems, perhaps, to be somewhat better tolerated than promin but it, too, has its disadvantages since it may produce tolerance, lethargy, dermatitis, primary exacerbation of cough and expectoration with secondary improvement of these, nausea and vomiting, nervousness, headache, diplopia and slight tremor. At no time were there any evidences of urinary disturbance but after careful observations of the blood "no serious or uncontrollable reactions have occurred" to date.

The authors conclude by stating:

WHAT ARE THE FACTS CONCERNING ORAL CATARRHAL VACCINES?



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Brand of Oral Catarrhal Vaccine

Nowhere is the manpower shortage more critical than in the nation's hospitals . . . nowhere is it more important to take every practical step to combat the common cold, which causes more illness and loss of working time than any other group of diseases.

Much has been written in the medical literature—both pro and con—concerning the value of oral catarrhal vaccines in preventing colds and their complications. However, the vast preponderance of evidence, based on controlled clinical studies, shows that oral vaccination *does* reduce illness and absenteeism resulting from colds.

REDUCES INCIDENCE, SEVERITY AND DURATION OF COLDS

Oravax is a small, white, enteric-coated tablet containing a wide range of antigens selected for their ability to build protection against organisms of secondary invasion responsible for debilitating sequelae of the common cold.

Published Clinical Reports on Oravax

Complete freedom from colds in 81.92% of Oravax group; in 12.34% of control group. *J. M. A. Georgia* 28:332-4 (*1939*)

In Oravax group, 3.7 days lost per person per cold; in control group, 6.75 days. *Canad. M. A. J.* 41:493 (*1939*)

Oravax 85% to 90% effective against loss of time. *Indust. Med.* 8:350-1 (*1939*)

70.2% of Oravax group free from colds; 7.2% of placebo group. *Indust. Med.* 9:530-3 (*1940*)

Incidence of severe colds in Oravax group 1/5 that in placebo group; *duration* of severe colds 0.6 day in Oravax group, 3.4 days in control group. *Journal-Lancet* 60:319-24 (*1940*)

Oravax is practical, easy to administer, costs less than 1¢ per day per employe. Write for sample and full information, including a complete clinical evaluation of oral vaccination incorporating all published work, both pro and con. Ask for Oravax hospital brochure.

Trademark "Oravax" Reg. U. S. Pat. Off.

MERRELL

116th Year

THE WM. S. MERRELL COMPANY · CINCINNATI, U. S. A.

"The administration of diasone in adequate doses has been accompanied by favorable clinical progress in the majority of patients studied by us without harm to the host. It, therefore, may be considered as an adjunct therapeutic agent and another indicator that the chapter of chemotherapy of tuberculosis, considered by many as closed, is really open to those who will continue to inquire, observe and evaluate."

In concluding their report involving the study of promin's effect in 36 cases, Hinshaw, Pfuetze and Feldman state: ". . . Progress is continuing at a satisfactory rate toward development of a clinically practicable chemotherapeutic agent for use in selected cases of tuberculosis. We believe that a great deal of work remains before attainment of this goal."

In this direction, Feldman, Hinshaw and Mann (Proc. Staff Meet. Mayo Clinic **19:** 25, 1944, Jan.) report favorably on a new, less toxic sulfone derivative, 4, 2′-diaminophenyl-5′-thiazolesulfone, known as promizole. This drug seems to offer real promise as a chemotherapeutic agent in the treatment of tuberculosis but, again, the esteemed members of the committee on therapy of the American Trudeau Society, of which Hinshaw is chairman, rightfully caution against blind optimism: ". . . Promin, diasone, promizole and certain related compounds appear to possess in varying degree the striking ability to restrain the development of experimental tuberculosis in guinea pigs. It is recognized that experimentally induced tuberculosis in guinea pigs offers many contrasts with clinical tuberculosis in human beings, even though the causative organism is the same.

"It is the opinion of the committee that the clinical and roentgenological data so far made available to the committee on the action of diasone in human tuberculosis are as yet inadequate both quantitatively and qualitatively to permit, even tentatively, a positive evaluation of its curative effects upon tuberculosis in human beings. . . .

"Until controlled studies of adequate scope have been reported it is recommended that none of these drugs be used for treating tuberculous patients except under conditions which will appreciably add to our knowledge of their clinical action, and in the presence of adequate facilities to protect patients effectively from their potentially serious toxic effects. . . .

"Any use of chemotherapeutic agents, including diasone, in the treatment of tuberculous patients must, therefore, be regarded as purely a project in clinical investigation. It must be again emphasized that such use is not without hazard and that the roentgenological and clinical evidence reviewed by the committee gives no justification at this time for any attitude concerning the value of these drugs in patients other than one of critical interest."

Hence, enthusiasm rises and wanes but steady progress ensues. The sulfones are indicative but not without hazard in the treatment of the tuberculous patient; synthetic specifics are frequently such two-edged swords. What does nature still hide from us —is it some as yet unknown, active, but nontoxic, naturally occurring specific? Time may yet reveal such a secret. The ultimate goal well justifies stupendous and relentless search for such a medicament.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Adhesive Without Irritation

In his article, "A Flexible Plastic-Liquid Adhesive," which appeared in the *Archives of Surgery* for December 1943, Rosenberg tells us that in an effort to combat the irritations, abrasions and dermatitis produced by adhesive plaster when used with wound dressings, he conducted a series of experiments among the patients in the division of pulmonary disease of Montefiore Hospital, New York.

A solution of polyvinyl butryal resin, 20 Gm.; alcohol (95 per cent), 120 cc.; ether, 20 cc., and castor oil, 10 cc., the author informs us, provides a liquid that possesses adequate adhesive qualities and elasticity, is easily removed and is inexpensive. The resin is placed in a mixture of alcohol and castor oil and allowed to dissolve without stirring or agitation. Admixture of air must be prevented.

After the resin is completely dissolved, the ether is added. Tests were carried out in which the basic solution was used with different plasticizers. Best results were obtained with the use of castor oil and organic compound as plasticizers.

In Group I, 175 patients (male and female) were used as subjects. Thirty of these were known to be sensitive to ordinary adhesive plaster. The liquid was applied to an area, 2 inches square, on the forearm of each patient and remained there for at least twenty-four hours and in no case was there any abnormality of the skin, any itching or other discomfort. Observations were also made a week later and the results were the same.

In Group II, 53 male and female patients were used. Nineteen of these had suffered adhesive plaster burns within the last two years. Four of these had adhesive plaster burns at the time of the tests. Much more extensive work was performed on this second group. Repeated application of the liquid adhesive on a gauze pad was tried until each patient had a total of from 28 to 30 tests. More than 1500 dressings were thus applied and all results were negative with the exception of three cases. In these cases, after periods of from seven to nine days, a slight redness accompanied by a minor irritation appeared on the removal of the dressings. After three or four days the symptoms disappeared and there were no other cutaneous manifestations.

The preparation is now available on a commercial basis.—JOHN F. CRANE.

X-ray of the Liver

Thorotrast (colloidal thorium oxide), injected intravenously, is taken up by the reticuloendothelial cells and produces clearly defined x-ray films of the liver and spleen. Such films show variations in size and position of the liver, the presence of gumma, metastases, abscesses, cysts or cirrhosis and the anatomical changes of a given pathological process. The authors, C. W. McClure, I. R. Jankelson and H. Osgood, in "Diagnostic Advantages of Thorotrast," *Review of Gastroenterology*, January 1944, disclaim any serious effects resulting from the use of thorium. Four cases are reported, two of which present carcinoma of the caecum with possible metastases to the liver, the other two refer to hepatic diseases. The injection of thorotrast was not followed by untoward reactions and its use is recommended in selected cases.—MICHAEL LEVINE.

FOOD SERVICE

Sixty Minutes Serves 6000

at the U. S. Naval Hospital St. Albans, N. Y.

ERNEST M. ANDERSON
York and Sawyer, Architects, New York City

AT THE St. Albans Naval Hospital, St. Albans, N. Y., a change in the construction program from permanent to temporary buildings and the rapid expansion of the bed capacity posed a problem in food service and distribution; its solution is of considerable interest.

Anticipating the need for additional hospital facilities in the New York area, the Navy Department planned early in 1942 to construct a permanent general hospital. As this need became critical, it was felt that temporary, one story wood framed structures, built while the permanent buildings were under construction, could provide urgently needed accommodations for the housing and treatment of patients in the shortest possible time.

To achieve this objective, a site reasonably close to New York City, of ample size, with fairly level ground and satisfactory environment, was required. The 116 acre St. Albans golf course selected easily met these requirements. In addition, it featured several groves of large, beautiful oak, maple, elm and other trees. The preservation of these trees became an important phase of the site planning.

The permanent hospital buildings were planned to be of reenforced concrete frame with brick masonry walls. The administration building, housing all surgical, laboratory, therapeutic and administrative areas, was to be six stories in height and was to be connected to three story ward buildings by means of fully enclosed, connecting corridors. Additional one story structures with basements and mezzanines were planned in this group to provide subsistence and recreation. Although the minimum of critical materials was designed to be used in these buildings, the Navy Department suspended construction when the foundations were completed to comply with a policy established at that time.

Other permanent structures required to service the temporary buildings, as well as the permanent buildings, and which were completed, included steam plant, laundry, fire house, garages and greenhouses. Semipermanent buildings, so called to distinguish them from the temporary structures and the concrete and masonry hospital buildings, were built to provide living and recreational quarters for nurses, hospital corpsmen, Waves and officers. These were generally wood framed, had plaster finished interior walls and ceilings, asbestos shingled exterior walls and slate roofs.

Designed to provide space for beds, treatment and feeding, the temporary buildings were planned on a horizontal basis, one story in height, with minimum use of critical materials. Of necessity, they were spaced as reasonably close as fire safety permitted. Originally intended to house 1500 beds, expansion made from time to time has increased this capacity to approximately 4200 beds. Within four and one half months from inception, the initial capacity of 1500 beds was available for occupancy; within six months all facilities had been completed. Occupancy by the

A view of the mess hall and chow line at the naval hospital. Official U. S. Naval photos.

Navy Department began at once.

Owing to the horizontal development of the temporary buildings on the site to provide hospital facilities as rapidly as possible, the solution of the problem of food service was quite important.

About 65 per cent of the patients are ambulatory and are expected to go to a central mess hall for their food. The remainder must be fed at the bedside. To meet these basic requirements a temporary subsistence building was constructed in a central area among the original group of ward buildings. This building housed storerooms, food preparation and galley areas, mess hall areas, ship's service and post office. When additional ward buildings were constructed an additional mess hall was built to reduce the distance of travel to the main mess in the original group.

All food is cooked in the subsistence galley. For the auxiliary mess hall it is placed in bulk food vacuum containers and delivered there by light motor trucks. Only broiled or "short order" food is cooked in the galley of the auxiliary mess hall, and even such food is prepared in ration form in the main galley.

The main mess seats in separate dining areas 265 hospital corpsmen and Waves, 305 staff members and 504 patients.

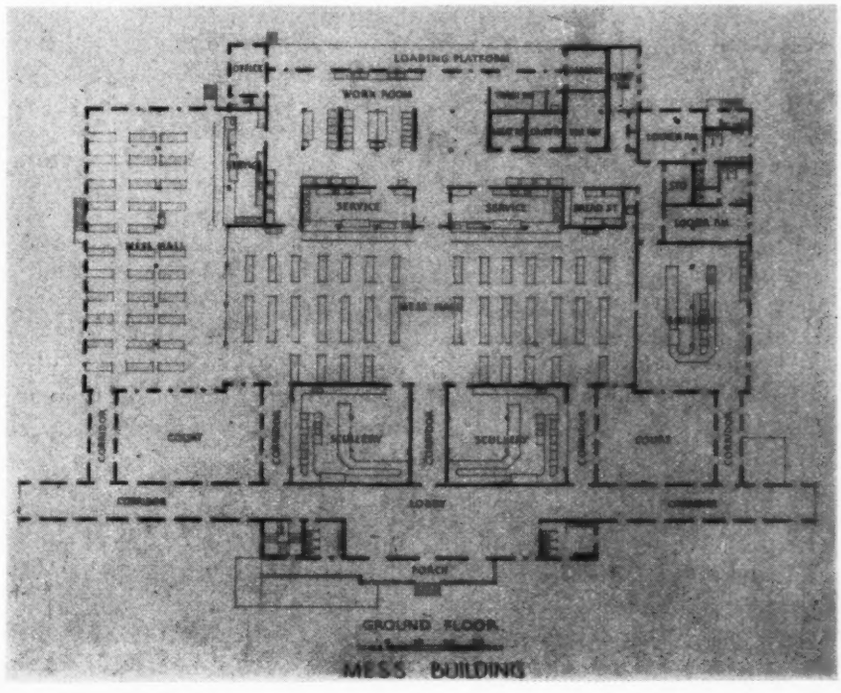
The auxiliary mess hall seats 265 corpsmen and Waves and 475 patients. Within an hour the main mess has served 3500 persons; the auxiliary mess has served 1100 persons and, including the ward service, about 6000 persons in all are served. An additional 1500 persons can be served in the smaller mess hall. Each dining area is provided with a self-service cafeteria counter. Except for staff and officers, each diner returns his plates on a tray to a central scullery, scrapes the plates and leaves them for washing. In the staff and officers' dining areas this work is performed by civilian help.

Food service to bedside in the wards is accomplished by means of electrically heated bulk food conveyors or "trucks." A truck service section in the main galley is set up to serve bulk food in cafeteria style. Each truck is in position in the order of its distance from the ward. On the way to and from the service counters each truck attendant picks up coffee, bread and butter. As he passes the food service counter the truck attendant calls out the number of patients to be served in his ward and the counter attendants fill the conveyor. Normally, this means food for up to 40 persons, yet it takes about 40 seconds to service the truck at this point.

Above: How the bulk food conveyor looks just before it is loaded on the delivery truck.

In a special diet truck section other attendants pick up—in a similar manner—the special diets needed for several wards. As each truck is filled, each attendant proceeds through the connecting corridors to his designated ward. Because of the horizontal development of the buildings the distance of travel to the wards farthest from the mess hall is approximately one third of a mile.

The food truck is brought to the diet kitchen in each ward. Under



Below: The ground floor plan of the central mess hall in which ambulatory patients eat.

supervision of the ward nurse the food is portioned out on dishes and trays kept for that purpose in the diet kitchens and then served to each bed patient. After service, the soiled dishes are stacked on a soiled dish truck and brought to the central sculleries for washing. When dried they are returned to each diet kitchen and shelved for the next meal in electrically heated plate warmers. The food conveyor is returned to a food truck washing and storing area adjacent to the main galley. When cleaned and dried it is lined up and made ready for the next service period.

In wards housing communicable disease cases, individual sculleries have been provided. The dishes in these wards are washed and sterilized after use and are not mixed with utensils used in the general ward.

Despite the overextension of the food services brought about by the development of the site with temporary buildings, such service is accomplished in a minimum of time—the complete cycle taking place within from forty-five to sixty minutes. The general excellence of the food has not been affected.

—How Others Do It—

Ingenuity Is the Answer

at Swedish Hospital, Seattle

MILDRED WHITCOMB

KEEPING up dietary standards with far fewer employes may seem an insurmountable problem but the ingenuity that some dietitians are showing is noteworthy. One of the inventive ones is Ruth Forsberg of Swedish Hospital, Seattle, a 300 bed institution noted for its excellent food service, war or no war.

While most of the other hospitals in this war-crowded Puget Sound area have long since abandoned the selective menu, Miss Forsberg has tenaciously held to this good-will builder. Inaugurated in 1933, the selective menu at Swedish Hospital began to build friends from the start and, while many times since the war began its temporary discontinuance has been discussed, Miss Forsberg has clung determinedly to this extra service. Now it has become one of the hospital's chief talking points. Many patients choose Swedish Hospital because their friends over the bridge table or war activity project tell about the good meals still served there.

When ration points have to be figured carefully, it would seem that the selective menu might be costlier in points, but Miss Forsberg ran a test and found that she was unconsciously balancing steaks and roasts with chicken and that no extra points were being used.

Dinner is served in the evening at this hospital but, in spite of the heavier meal coming late, the kitchen help is out and the kitchens are locked by 8:30 p.m.

As far as Swedish Hospital was concerned it was an unprecedented thing, this locking of the kitchen at 8:30 o'clock, and called for considerable readjustment on the part of the nurses who had long been accustomed to get anything from the kitchen at any hour up until midnight. They have long since become adjusted to the new routine with no ensuing unhappiness for the patient. All requests for extras must be anticipated so that they can be delivered to the floors before closing time.

To understand the Swedish Hospital system it is necessary to know that there is central food service, the dinner leaving the kitchen at 5 p.m. for the floors. This leaves ample time for the dishes to be returned for washing before the kitchen staff goes off duty.

Cafeteria service takes care of student and graduate nurses, interns and other employes. When nurses and interns come down to select their evening meal from a comfortable variety of dishes, they pick up their night lunch off a shelf at the cashier's station and take it with them to their floor diet kitchens when they leave.

The lunch consists of sandwiches, pickles, cake and a bottle of milk. Coffee is made on the floors. Single lunches and double lunches are offered. Those nurses who go off duty at 11 p.m. will want no more than a single lunch. Those who work the 11 p.m. to 7 a.m. shift will want larger lunches.

Night lunches are packed by the sandwich maker, a woman employe who works four hours daily. She comes on duty before lunch and makes the sandwiches served at the cafeteria counter for those who wish a lunch of that type. After the cafeteria lines are closed she makes the sandwiches for the night lunches, wrapping them carefully in waxed paper—one sandwich for the single lunch, two sandwiches for the double lunch. She also wraps the other night lunch items individually, packs them in a brown paper bag and places them on the shelf of the cashier's counter. Her day's task is then complete.

Miss Forsberg asks the visitor to note particularly the age level of the kitchen employes. It is high.

"I'm a great admirer of these older women," she asserts. "When the war is over I mean to keep them on the

Toast Cure for Food Cynics at The University of Chicago Clinics!

ELLA M. ECK
Chief Dietitian
University Clinics
The University of Chicago

The units of The University of Chicago, of which Miss Eck is chief dietitian, are the Albert Merritt Billings Hospital, Bobs Roberts Memorial Hospital for Children, and, by affiliation, The Home for Destitute Crippled Children. Despite the many responsibilities which such a group of institutions imposes, Miss Eck has always been active in association work. She is a former treasurer of the American Dietetic Association and a former president of the Illinois Dietetic Association.

That no-place-like-home attitude suffers a setback as still another clever dietitian adds zest to hospital meals by using *Toastmaster* toast in the recipe. It's a simple way to put more eye-appeal into just about any dish you serve. And, once patients get that first taste of the crunchy goodness with which *Toastmaster* toast sharpens a dull appetite, even the most confirmed "nibbler" finds it useless to resist. On the administrative side, in these days when good help is hard to find, it's a comfort to know that your *Toastmaster** toaster is never slipshod, never wasteful . . . pops up perfect toast every time without watching, turning, or burning.

SALMIS OF DUCK A LA JULIENNE

Place several thin strips of roasted duck inside four triangles of *Toastmaster* toast. Cover with a rich brown sauce made of onions, mushrooms, butter, and drippings from the roasting pan, flavored with lemon juice and sherry. Top with mushroom and serve with *Toastmaster* toast. Garnish with lemon slices, ripe olives, and parsley.

*"TOASTMASTER" is a registered trademark of TOASTMASTER PRODUCTS DIVISION, McGraw Electric Company, Elgin, Illinois

STRETCH HARD-TO-GET FOODS WITH DELICIOUS

TOASTMASTER REG. U.S. PAT. OFF. *Toast*

The National Habit Wherever Folks Eat!

job just as long as they want to work.

"The only point in their disfavor is that they get tired and occasionally want a day or two off. But they have far more stamina than most of the young ones. We hire a healthy looking young woman and in two or three days she walks out, saying she can't stand the work; it's too hard on her feet.

"Look at that woman there at the pots-and-pans sink. We used to have a man on that job. But he didn't do the careful job she does, nor did he mop up the floor around the sink after the work was done. Only a good housekeeper would do that."

A visitor will notice not only the age level but the general intelligence level of these workers. Most of them look like the neat, sensible middle-class housewives that they undoubtedly have been until the war condition or war wages have induced them to work outside the home.

Uniforms Will Aid Morale

Miss Forsberg is putting her kitchen workers back in uniform soon. She has 12½ dozen uniforms on order, having finally succeeded in getting the promise of a shipment from a linen supply house. Just white Hoover aprons they will be but they'll add to the smart appearance, general cleanliness and morale of the workers.

The hospital furnishes and launders work aprons to be worn over the uniforms but each worker must pay a deposit on her uniforms and launder them herself, owing to help shortages in the laundry department.

Just how large a deposit will be required on the uniforms is still under debate but it will probably be $5 or $6 for the three uniforms furnished. When a worker leaves, she has only to turn in the three uniforms to get her deposit money back.

"We learned a valuable lesson in locker keys," Miss Forsberg declares. "We used to charge employes a 25 cent deposit on their keys and many workers would lose three or four keys a year. Now keys are almost impossible to get but we find we have no problem of lost keys. We charge a deposit of $1 for a key and since we stiffened the penalty for carelessness not a single key has been lost."

Through foresight and good planning, Swedish Hospital's dietary department can function more efficiently under war conditions than can those of many hospitals. A remodeling and reequipping job was done just before the war began and the kitchens were expanded to care for a rapidly expanding plant.

Though a bit below ground level the windows are almost full height and numerous skylights admit natural light into the work areas. Soundly placed for economy of motion, the rows of stainless steel equipment would be the envy of half the dietitians in the country. Miss Forsberg has no battery of pans, strainers and utensils hanging over the heads of the workers. She wants a clear vista and she has it. All equipment not in use is concealed in cabinets below counters and work tables.

While the chief dietitian's office—a room that has both charm and efficiency—is located on the main floor just two doors down the principal corridor, a second dietitian's office is placed at one end of the kitchen area. It has space for three or four assistant dietitians and above a wainscot has sliding glass partitions. From one desk the dietitian can survey the length of the cooks' galley and the kitchen proper and can answer any questions or inspect the food preparation while her desk work continues. Another dietitian's desk overlooks the serving unit and the glass partition on the third side of this office gives upon the diet kitchen.

A third office near the elevators is occupied by the assistant dietitian who handles personnel. Its more isolated location makes it ideal for interviews.

Although the hospital administration was not quite ready for an employes' cafeteria when the kitchen remodeling program was being done, the kitchen help situation became so acute that two years ago a pay cafeteria system was introduced. It has been a great success.

The kitchen remodeling plan had been arrived at after long contemplation and Miss Forsberg maintains that what the visitor now beholds so appreciatively is Plan No. 16, or some such, and she had looked ahead even then to a cafeteria setup so not much had to be done structurally when the cafeteria was inaugurated. Space did not permit an ideal setup but the compromise necessitated by circumstances has worked out most satisfactorily.

One ingenious idea on the cafeteria counter is worth passing on. Free circulation about the kitchen and dining rooms precluded as long a cafeteria service line as was necessary. To overcome this obstacle, the house carpenter made a wood section on wheels which holds the silver, napkins and trays and during mealtimes this cart is attached to the cafeteria counter to form a continuous line. When the meal is over it is detached and wheeled out of the way and a passageway is opened up to the dining rooms and corridor.

The dining rooms are attractive—pale green walls, a large floral print on the end wall between two arched niches (part of the original construction), a mottled rose and beige floor covering (a local product made of cork and cement, very easy on the feet) and tables finished with deep peach tops. Venetian blinds at the windows have maroon tapes. The first tapes were a deep rose but they soiled too quickly and had to be replaced. Before the linen shortage the tables had heavy pads and colored cloths. These not only added to the beauty of the room but supplemented the perforated ceiling tiles in acoustical correction.

Soundproofing is general throughout the kitchens, as well. Perforated tiles cover all ceiling areas and form a border below the skylight glass.

The cafeteria counter occupies one corner of the great kitchen and when the hour for meal service begins one of the kitchen workers moves into place two large painted screens that shut off from the patrons a view of the kitchen itself.

They Still Have Silverware

Not only did administrative foresight make war food service easier both for patients and for employes through enlargement and reequipment of the kitchens but some extrasensory perception must have guided the chief dietitian to purchase heavily of china and silverware.

Three sets of chinaware can still be used intact and there is none of this dull war-time flatware to discourage the appetites of patients. Some way Miss Forsberg finds the help to keep her serviceable prewar silver brightly burnished so that neither patients nor employes at the Swedish Hospital need realize there is a war on when it comes to food service.

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- ☐ 871G Quantity Recipe Cards

*Name*_____
*Title or Position*_____
*Hospital or Organization*_____
*Address*_____
*City*_____ *Zone*_____ *State*_____

Menus for November 1944*

Dorothy L. Osler
Children's Hospital
Columbus, Ohio

1
Orange Slices
Baked Eggs
Buttered Toast
Milk

•

Broiled Beef Patties
Mashed Potatoes
Buttered Green Beans
Tomato Wedges
Pitted Prunes With
Custard Sauce

•

Cream of Celery Soup
Baked Potato
Cottage Cheese
Jellied Vegetable Salad
Graham Cracker
Sandwiches

2
Tomato Juice
Crisp Bacon
Buttered Toast and Jelly
Cocoa

•

Roast Pork
Parslied Buttered Potatoes
Hot Applesauce
Tossed Vegetable Salad
Sliced Bananas

•

Poached Egg on Toast
Mashed Squash
Pear-Cheese Salad
Cottage Pudding With
Fruit Sauce

3
Stewed Apricots
Scrambled Eggs
Buttered Toast
Milk

•

Flaked Fish
Escalloped Potatoes
Stewed Tomatoes
Carrots
Lemon Pudding

•

Macaroni and Cheese
Lettuce Sandwiches
Buttered Brussels Sprouts
Orange Slices
Apple Betty

4
Orange and Grapefruit
Juice
Bacon Curls
Buttered Toast
Milk

•

Creamed Diced Ham on
Dutch Rusks
Buttered Cauliflower
Apricot Salad
Raisin Rice Custard

•

Lamb Patties
Baked Potato
Creamed Celery
Apple Wedges
Floating Island

5
Sliced Bananas
Coddled Eggs
Raisin Bread Toast
Cocoa

•

Roast Beef
Mashed Potatoes
Buttered Peas
Orange and Grapefruit
Sections
Ice Cream

•

Vegetable Soup
Peanut Butter Sandwiches
Egg Salad Sandwiches
Sliced Peach on Lettuce
Baked Apple

6
Stewed Prunes
Crisp Bacon
Buttered Toast and Jelly
Milk

•

Spaghetti With Tomato
Sauce
Baked Beef Patties
Spinach With Lemon
Lettuce Wedges
Orange Bread Pudding

•

Creamed Chicken on Toast
Points
Buttered Diced Beets
Celery Hearts
Fruit Cup
Vanilla Wafers

7
Applesauce
Baked Eggs
Buttered Toast
Cocoa

•

Liver and Vegetable
Casserole
Parslied Buttered Potatoes
Shredded Cabbage,
Sour Cream Dressing
Gingerbread

•

Baked Rice and Cheese
Buttered Green Beans With
Bacon and Onions
Prunes Stuffed With
Orange Sections
Fruit Cream

8
Orange Slices
Scrambled Eggs and Bacon
Buttered Toast
Milk

•

Individual Shepherd's Pie
Stewed Tomatoes
Crisp Lettuce and Egg
Salad, Dressing
Apricot Whip

•

Escalloped Sweet Potatoes,
Apples and Marshmallows
Cold Sliced Ham
Grapefruit Salad
Baked Custard

9
Grapefruit Sections
Soft Cooked Eggs
Buttered Toast
Cocoa

•

Roast Leg of Lamb
Parslied Buttered Potatoes
Buttered Whole Carrots
Celery Hearts
Banana and Orange Cup

•

Cream of Corn Soup
Toasted Cream Cheese and
Raisin Sandwiches
Diced Beets
Jellied Vegetable Salad
Ice Cream Bars

10
Tomato Juice
Sweet Rolls
Milk

•

Salmon Loaf
Creamed Diced Potatoes
Buttered Brussels Sprouts
Orange Slices
Creamed Rice Pudding

•

Scrambled Eggs
Baked Acorn Squash
Buttered Spinach
Carrot Sticks
Baked Apple

11
Stewed Prunes
Baked Eggs
Buttered Toast
Milk

•

Beef Stew With Vegetables
Corn Meal Muffins
Head Lettuce and Tomato
Wedges
Banana Custard

•

Cottage Cheese
Baked Stuffed Potato
Buttered Diced Rutabagas
Pineapple and Pear Salad
Orange Ice

12
Tangerine
Crisp Bacon
Buttered Toast and Jelly
Milk

•

Roast Chicken
Mashed Potatoes
Buttered Baby Green Lima
Beans
Carrots and Pineapple in
Gelatin
Chocolate Ice Cream

•

Vegetable Plate With
Poached Egg on Toast
Jellied Fruit Salad
Oatmeal Cookies
Cocoa

13
Sliced Bananas
Scrambled Eggs
Buttered Toast
Milk

•

Broiled Wieners
Baked Potato
Eight Minute Cabbage
Raw Apple Wedges
Sliced Peaches

•

Escalloped Corn
Bacon
Buttered Diced Beets
Grapefruit Sections and
Lettuce
Apricot Bavarian Cream

14
Orange Juice
Coddled Eggs
Buttered Toast
Milk

•

Meat Loaf
Oven-Browned Potatoes
Creamed Onions
Tossed Vegetable Salad
Fruit Cup

•

Jelly Omelet
Escalloped Potatoes
Buttered Asparagus
Raw Spinach Salad With
Grated Carrot
Prune Whip

15
Stewed Apricots
Bacon Curls
Buttered Toast
Milk

•

Roast Loin of Pork
Baked Sweet Potato
Hot Applesauce
Crisp Cabbage Slaw
Blueberry Pudding

•

Potato Soufflé
Bacon
Buttered Diced Turnips
Watercress and Egg Salad
Pear Half
Cocoa

16
Sliced Bananas
Poached Eggs
Buttered Toast
Milk

•

Broiled Beef Patty
Spaghetti With Tomato
Sauce
Day-Old Buns With Butter
Lettuce Hearts
Fruit Gelatin

•

Escalloped Lamb
Mashed Potatoes
Buttered Green Beans
Carrot and Pineapple Salad
Chocolate Pudding

17
Orange Slices
French Toast With
Sirup
Milk

•

Eggs à la Goldenrod
Buttered Broccoli
Celery Cabbage Rings
Baked Apple

•

Oyster Stew
Tomato and Lettuce
Sandwich
Pear and Cottage Cheese
Salad
Lemon Rice Cream

18
Stewed Prunes
Coddled Eggs
Buttered Toast
Cocoa

•

Escalloped Chicken
Parslied Buttered Potatoes
Buttered Whole Kernel
Corn
Turnip Sticks
Canned Apricots

•

Vegetable Stew
Egg Salad Sandwiches
Fruit Gelatin
Oatmeal Cookies

19
Applesauce
Crisp Bacon
Buttered Toast
Apple Butter
Milk

•

Baked Ham With Raisin
Sauce
Mashed Sweet Potatoes
Buttered Peas
Celery Hearts
Ice Cream

•

Poached Egg on Rice Nest
Broiled Tomato Slice
Cabbage and Apple Salad
Sliced Oranges and
Bananas

20
Tomato Juice
Scrambled Eggs
Buttered Toast
Milk

•

Broiled Liver
Brown Rice With Tomato
Sauce
Buttered Carrots
Lettuce Hearts
Fruit Cream

•

Toasted Peanut Butter
Sandwiches
Spinach Soufflé
Peach-Cottage Cheese
Salad
Red Raspberry Ice

21
Grapefruit Sections
Baked Eggs in Bacon Ring
Buttered Toast
Milk

•

Diced Beef and Noodles
Creamed Cauliflower
Whole Wheat Muffins
Apple, Celery, Raisin Salad
Canned Italian Plums

•

Baked Acorn Squash
Stuffed With Beef Patty
Escalloped Tomatoes
Jellied Vegetable Salad
Gingerbread With Fruit
Sauce

22
Stewed Prunes
French Toast With
Sirup
Milk

•

Lamb Patties
Creamed Potatoes
Buttered Brussels Sprouts
Lettuce Hearts
Apricot Whip

•

Creamed Dried Beef
Baked Potato
Buttered Lima Beans
Apple Wedges
Orange Ice

23
Orange-Grapefruit Juice
Soft Cooked Eggs
Buttered Toast
Cocoa

•

Roast Turkey With
Dressing
Mashed Potatoes
Giblet Gravy
Buttered Peas
Celery, Cranberry Jelly
Pumpkin Custard

•

Cream of Parsley Soup
Cold Sliced Ham
Fruit Salad
Ice Cream
Sugar Wafers

24
Sliced Bananas
Baked Eggs
Buttered Toast
Milk

•

Scrambled Eggs
Baked Potato
Beets With Lemon Butter
Crisp Cabbage
Fruit Custard

•

Creamed Salmon
Buttered Diced Potatoes
Spinach With Lemon
Tomato Wedges
Sliced Peaches

25
Grapefruit Sections
Crisp Bacon
Raisin Bread Toast
Milk

•

Ham Loaf
Creamed Diced Potatoes
Mashed Rutabagas
Sliced Pineapple Salad
Custard Bread Pudding

•

Vegetable Soup
Cheese Soufflé
Grated Carrot and Raisin
Salad
Fruit Cup
Vanilla Wafers

26
Tomato Juice
Cinnamon Toast
Scrambled Eggs With Ham
Milk

•

Roast Chicken
Mashed Potatoes
Buttered Peas and Celery
Diced Beets in Lemon
Gelatin
Angel Food Cake

•

Egg in Spinach Nest
Creamed Cauliflower
Apple, Celery, Raisin Salad
Graham Cracker
Sandwiches

27
Stewed Prunes
Poached Eggs on Toast
Cocoa

•

Meat Loaf With Tomato
Sauce
Buttered Potatoes
Creamed Green Beans
Grapefruit Sections
Spanish Cream

•

Diced Beef and Vegetables
Baked Squash
Lettuce-Tomato Salad
Apricot Halves
Sugar Wafers

28
Orange Slices
Crisp Bacon
Buttered Toast and Jelly
Milk

•

Roast Beef
Mashed Potatoes
Eight Minute Cabbage
Carrot Sticks
Tangerine Sections

•

Baked Eggs
Crisp Bacon
Escalloped Tomatoes
Pear Half on Lettuce
Butterscotch Pudding

29
Sliced Bananas
Coddled Eggs
Buttered Toast
Milk

•

Lamb Loaf
Escalloped Potatoes
Buttered Turnips
Lettuce Wedges
Applesauce
Gingersnaps

•

Baked Liver
Creamed Potatoes
Broiled Tomato Slices
Celery Curls
Baked Custard

30
Tomato Juice
Scrambled Eggs and Bacon
Buttered Toast
Milk

•

Creamed Chicken on
Buttered Rice
Buttered Peas
Raw Spinach With Grated
Carrot
Strawberry Ice Cream

•

Broiled Wieners
Baked Potato
Buttered Green Beans
Raw Cauliflower
Lemon Snow With Custard
Sauce

---

* While these menus are for children of from 5 to 16 years, they can be adapted for the use of adult patients and personnel.—Ed.
Ready-to-eat or cooked cereals are offered on all breakfast menus.

IN THE SHORTENING OF

Convalescence

More than so-termed tonics and restoratives, Ovaltine can be of material aid in shortening the period required for the return of strength and vigor following recovery from infectious or prolonged illnesses.***During the acute stages of febrile diseases, when the patient's nutritional intake is low, while requirements are higher than normal, many metabolic deficits are developed. These can be made good only by a high intake of essential nutrients during the recovery period. For only after these nutritional deficits are wiped out can former strength be regained, can a normal feeling of well-being return.

Ovaltine offers many advantages as a nutritional supplement to the dietary of convalescence. The delicious food drink composed of 8 ounces of milk and ½ ounce of Ovaltine is rich in minerals, vitamins, and biologically adequate proteins. Its appealing taste invites consumption of three or more glassfuls daily. Its low curd tension encourages rapid gastric emptying, an important factor in maintaining good appetite.

THE WANDER COMPANY, 360 North Michigan Avenue, Chicago 1, Illinois

Ovaltine

Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	750 I.U.	2203 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.

CONDUCTED BY W. W. DAVISON

A Kansas Hospital Outwits the Weatherman

A NEWCOMER to Hays, Kan., once reported in his diary that "there are 22 saloons, three dance halls, one small grocery and one clothing store. We think nothing of having one or two dead men on the streets nearly every morning. There is no law except the law of the six-shooter."

Today is different. In the new wing of the Hadley Memorial Hospital the concern for human life is so great that it is in the vanguard in providing for the welfare and comfort of patients. This new wing, a gift of the Hadley family for which the hospital is named, incorporates the newest system of air conditioning and other improvements in hospital construction.

The new air-conditioned unit is of reenforced concrete and brick construction with acoustic tile walls, partitions and ceilings and fire-resistant acoustic floor covering. The windows are double glass construction with intervening air space throughout. The upper two thirds of the windows are immovable; the lower third is hinged from the bottom and opens inward if desired. Screens are of a special design to deflect solar heat. No effort has been spared to erect a building that lends itself to perfect air conditioning.

All Apparatus in Basement

The air-conditioning system itself is of a new type that permits location of the main apparatus in the basement, use of all fresh air with no intercirculation among the rooms and permits adjustment of the temperature, in both summer and winter, individually for each room.

In designing the new wing, the architect, Charles W. Shaver of Salina, Kan., specified the following requirements for the air-conditioning installation:

1. Individual control of room temperature, both summer and winter, with temperature variations among the rooms, if desired.
2. Conditioned outdoor air to be supplied from the main apparatus so that the air from one room cannot be mingled with the air in other rooms.
3. Cooling and dehumidifying in summer and heating and humidifying in winter.
4. No transmission of noises from adjoining rooms through the air-conditioning system and a low sound level in the system.

Here Are More Advantages

These specifications were met by the new system, which gave additional advantages as follows:

1. Each room's unit, located below the window sill, uses the same coil for both heating and cooling, thus saving expense and floor space.
2. The unit supplies air upward, preventing cold downdrafts across the floor from the window in winter and drafts across the occupant in summer.
3. Maintenance costs are low owing to the absence of moving parts in the room unit.
4. There is no accumulation of odors and the cooling coil remains dry because the air is dehumidified before being carried to the unit.
5. Installation, maintenance and operation are simple.
6. Savings of from 80 to 85 per cent in space and consequent economies in materials and labor costs of construction have been effected because the conduits that bring the hot or cold water and the air are smaller than the customary air ducts and are easier to install. No return ducts are required.

The air-conditioning system consists of three major parts: (1) the main apparatus that cleans the air taken in from outdoors and fixes the moisture content at the desired percentage at all times; (2) the pipes that deliver water and the small conduits that deliver air from this main apparatus to each room, and (3) the unit that circulates conditioned air in each room.

In general outlines the system is similar to that installed in the Statler Hotel in Washington, D. C., which was described in the May 1944 issue of this magazine (page 112).

Dials on these individual room units permit the nurse to set the temperature at whatever level is considered most desirable for each individual patient.

Dr. Clyde D. Blake, chief of staff of Hadley Memorial Hospital, was asked by The MODERN HOSPITAL to give his opinion on the air-conditioning system. He wrote in part as follows.

Difference Between Life and Death

"It has been one of the most delightful experiences we have had, both to the patients and to the hospital personnel. The end in view is to provide added comfort to seriously ill patients recovering from major surgical procedures or a critical illness when minor comforts may mean the difference between recovery and death.

"Having cared for many such patients, both before and after air conditioning, it has been amazing and most comforting to me to observe

EFFICIENT LAUNDRY LAYOUTS DON'T HAPPEN BY "MAGIC"!

IT TAKES THE KIND OF THOROUGH PLANNING THAT HOFFMAN ENGINEERS ARE EQUIPPED TO DO

When you see a laundry that provides a smooth flow of work—with a minimum amount of retracing of steps—you see the result of careful planning! From an operating standpoint, the hospital laundries installed by Hoffman are notably successful. Hoffman assistance in planning the layout assures you of highest output with minimum labor, and a smooth forward flow of work that means real economy of operation. Experienced Hoffman engineers are available now—to survey your needs and make recommendations.

ARMY E NAVY

POUGHKEEPSIE PLANT

U. S. HOFFMAN MACHINERY CORPORATION

107 Fourth Ave., New York 3, N.Y.

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

the marked difference in their appearance when confined to bed in the air-conditioned wing and when bedfast in our old unit.

"In the old unit it was impossible in any way to produce an environment of comfort by window ventilation and the use of electric fans. Especially was this true during the hot summer months when we must expect periods of excessive temperature reaching as much as 110° F. with markedly variable humidity, disturbing outside noises, dust and drafts.

"During the winter months, hot water is forced through coils in the individual air-conditioning units in each room. Air is forced through the ducts by fans and then goes through multiple vents by the hot water coils, thus being warmed to the desired temperature. This is outside air that has been filtered, dehumidified and then rehumidified to the proper level. It constitutes about 20 per cent of the air that is blown into the room, the other 80 per cent being air from the same room that is recirculated. These units are thermostatically controlled and can be varied from a room temperature of 70° to 85° F.

"In the summer, the water circulating through the units is cooled by refrigeration and the room temperature is automatically maintained at the determined level within a tolerance of 4 or 5 degrees.

Relatives Are Happy, Too

"The advantages of this new unit which I have noted are: (1) The comfort of the patient is greatly increased. To see the expressions of seriously ill patients in these rooms on a hot humid day as compared to the patients in the old unit is comforting to relatives and heartening to the attending medical and nursing staffs. (2) There is a great reduction in the loss of fluids by perspiration during hot weather. (3) There is a decided saving of nervous energy. (4) There is freedom from outside noises owing to the type of building construction. (5) There is freedom from odors, owing to the character of the air-conditioning system. (6) There is freedom from outdoor dust, smoke and soot. (7) There is freedom from drafts. (8) There is freedom from inside odors, such as ether fumes, cigaret or cigar smoke and odors from patients' wounds. (9) There is a constant impression of air freshness throughout the entire wing. (10) Nursing care in the hot weather is simplified.

"In my opinion, the gratitude of the patients served and the unbounded appreciation of the medical, surgical and nursing staffs will repay the planning board for the installation of such a system. Air conditioning must, of necessity, in most hot areas be of major importance in future hospital construction."

Figuring Fuel Savings

W. F. SCHAPHORST
Mechanical Engineer, Newark, N. J.

MANY a hospital official has asked a glib-tongued salesman to be more specific regarding fuel savings. During these times we are not so much interested in percentages and indefinite data as we are in the actual *money* that can be saved by saving fuel.

With this in mind I have developed some rules, which anyone can apply, to assist in determining the exact amount of money you can save per year by reducing chimney gas temperature.

It is well known that reduction of chimney gas temperature is important. It is attained in numerous ways, the commonest of which are: (1) by baffling the boiler in such a way that there will be no short circuiting of the hot gases through cracked or broken baffles; (2) by maintaining a constant gas velocity through all of the boiler passes; (3) by cross-baffling; (4) by increasing radiation-absorbing surface; (5) by modernizing the furnace; (6) by keeping the tubes free from ashes and soot; (7) by keeping the tubes free from scale; (8) by installing an economizer; (9) by installing an air preheater, and (10) by installing a superheater.

Any process that makes good use of the heat in the exit gases causes a temperature drop and saves money. But I shall not go into that phase of the subject here. What I want to present is the method by which you can estimate money savings.

It is necessary to know only four things: (1) the present boiler efficiency; (2) the heat value of fuel in Btu. per pound; (3) the temperature of the chimney gases now, before making any improvements, and (4) the promised temperature of the chimney gases after the improvements are made.

First, multiply the present boiler efficiency by the heat value of the fuel in Btu. and call the result A.

Then subtract the temperature of the chimney gases *after* improving from the temperature of the chimney gases *before* improving, multiply the difference by 457 and call the result B.

Divide A by B, add 1 to the quotient and call the result C.

Divide your present annual fuel cost in dollars by C. The quotient is the result you want, the money that will be saved by making the improvement.

Here's How It Works Out

In order to check up and to be certain that you follow the rules correctly, let us take a typical example: If your present boiler efficiency is 70 per cent; if the heat value of the fuel is 12,000 Btu. per pound; if the temperature before making the improvement is 600° F., and 500° F. after making the improvement, and if your present annual fuel cost is $100,000, by substituting the figures for the letters given in the rules you will find that your saving will be $5150 a year.

The rules are based on the assumption that upon making the improvements the proper amount of air will be used in the process of combustion —neither too little nor too much. Eighteen pounds of air to each pound of fuel is usually regarded as good.

ENGINEERS' QUESTION BOX

Soot Blowing

Question 52: Does it make much difference how often we clean out the soot in our boilers?—A.C.F., Ill.

ANSWER: Soot is one of the most efficient insulating materials known. It has a remarkable affinity for attaching itself to boiler tubes. It is one ever-present and ever-increasing enemy of efficiency.

Soot begins to form the moment after the previous layer has been removed. In six hours the deposit in any boiler is sufficient to affect the flue temperature. Every 33° rise in flue temperature represents a waste of 1 per cent of the coal fired. In eight hours, even with fairly clean combustion, the deposit of soot on the tubes will cause a rise of 50° in the stack temperature and in twenty hours it may cause a rise of 100°.

Soot, therefore, should be blown every six hours. The observed saving by the use of effective soot blowing is often 3 per cent. Assuming a boiler operating at 500 h.p., a saving of 3 per cent would return the cost of a mechanical soot blowing installation in less than one year!

In a water tube boiler, it is physically impossible properly to clean the heating surfaces by hand. Firemen object to wrestling with a hot steam lance in a narrow alley and they will not do it oftener than they are absolutely compelled to.

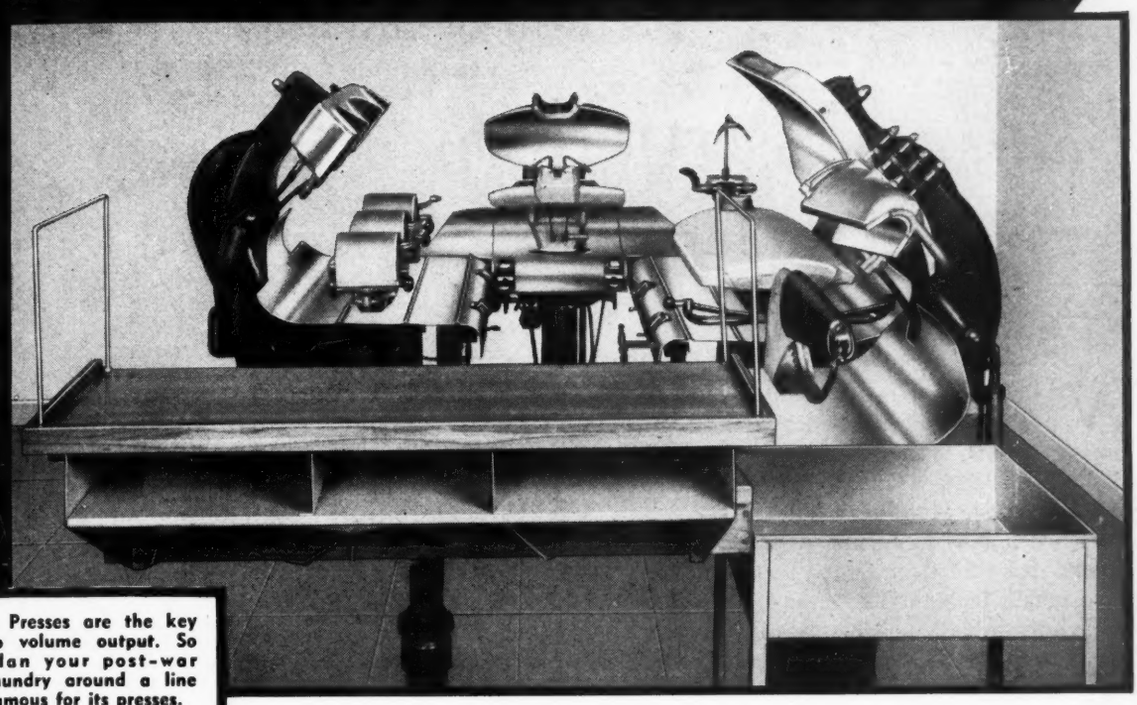
Mechanical soot blowers are much more easily operated; they do the work more effectively and thus pay for themselves quickly.

If your fire doesn't make soot, you won't get any on the heating surface. Therefore, it pays to watch your furnace and do everything possible to obtain smokeless combustion. Study your type of boiler to find where soot lodges most easily. Then give special attention to these points.

Boilers differ greatly in their tendency to retain soot among the tubes. Where cleaning is difficult, extra effort is required. *But the important thing is to get it clean.*

Remember that soot not only acts as an insulator but, when wet by steam condensation or leakage, produces an acid which will corrode the heating surface with which it comes in contact. Soot is your constant enemy.

In low-pressure plants, automatic soot blowing, of course, is impossible and hand cleaning must be substituted. —JOSEPH HARRINGTON, *advisory engineer on coal and its uses, U. S. Bureau of Mines, Chicago.*



Presses are the key to volume output. So plan your post-war laundry around a line famous for its presses.

- Shirt Finishing Units
- Wearing Apparel Finishing Units
- Uniform Finishing Units
- Dry Cleaning Presses
- Fully Automatic End-Door Washers
- Automatic Control for Conventional Wash Wheels
- Fully Automatic, Fully Closed Dry Cleaning Units
- Quick Centering Hydro-Extractors
- Chest-type Flatwork Ironers

No Hand Finishing with the

PROSPERITY

2-GIRL SHIRT UNIT

Get Higher Production, Finer Quality, At Lower Costs

For about a quarter of a century, Prosperity finishing presses have stood in the forefront—recognized leaders in pressure, speed, safety, mechanical and operating simplicity, and in quality of finish produced.

Typical is this Prosperity Two-Girl Unit—a result of years of research and leadership in the field of shirt finishing. It is a unit that will completely machine finish every part of every shirt. It does away entirely with the slow and cumbersome job of hand-finishing which costs money.

The unit consists of the 2440 PC collar and cuff press; 3240 PC bosom and body press; 1025 P.O. two-lay sleeve press; 821 P.O. yoke and shoulder press and folding table. All combine to give you finer finished shirts at a greater production and at a lower cost. Because of the quality finish and high output of this unit, you can offer incentive wages that will attract the most skillful operators, assuring you a uniformly high volume of high quality work.

Conducted by Alta M. La Belle

Blanket Instructions:

for better appearance and longer life

MRS. VERA BURLINGAME
Executive Housekeeper
Charles T. Miller Hospital
St. Paul, Minn.

WITH woolen materials at a premium under present wartime conditions, it has become increasingly necessary that woolen blankets receive careful handling. There are a few fundamental precautions that should be taken in order to obtain both the maximum of service and the best possible appearance during the life of the blanket.

First of all, blankets should be of a good quality. At Charles T. Miller Hospital, St. Paul, Minn., almost all of the blankets used for patients are 100 per cent wool, while those used in the nurses' residence are 50 per cent wool and 50 per cent cotton.

Blankets Numbered Consecutively

Blankets used for private patients, ward patients and hospital personnel are numbered in three different groups consecutively and according to the station to which they are issued. This enables the housekeeping department to know how many are in use on each station at all times and provides a certain check regarding the causes for replacements.

Three blankets are available for each private patient—two for the bed and one for the chair. Two blankets are provided for each ward patient, although one is left in the linen closet until it is needed.

At this point a word might be said regarding the color of the blankets selected. It is obvious that hospitals are becoming increasingly aware of the pleasure derived from attractive details in the sickroom; that is why patients' rooms are decorated in pastel tints and why the draperies and slip covers are colorful. For the same reason, it is important that blankets be of a cheerful, as well as a practical, color and we have found that the peach and cedar hues qualify in both respects.

It would be difficult to make a general statement regarding the frequency of launderings, for this depends entirely upon the circumstances encountered. However, blankets should be laundered sufficiently often to be fresh and clean at all times.

In laundering blankets at Miller Hospital, we follow a definite procedure, and the care that is taken in the laundering process produces results that would be a delight to any housekeeper.

A small pony washer of the cylinder type is used for laundering blankets. It can be operated at two speeds, but only the lower speed motion is used.

At all times during the laundering process, it is exceedingly important that the water be maintained at a constant temperature to avoid shrinkage and felting. We have found that the results are most satisfactory when the temperature is maintained at approximately 90° F. However, the most important issue is that subsequent suds and rinses be maintained at the same temperature as the original suds.

Briefly, our formula is as follows:

First, the machine contains a heavy suds with water at approximately 90° F. before it is loaded. (I might state at this point that it is taken for granted that the water is soft.) A low titer soap is used, which dissolves rapidly in water at a low temperature.

Keep Suds Level High

It is immensely important that a sufficiently high suds level be used, and for this reason it should be carefully watched. Certain medications, as well as plaster of paris, will radically reduce the suds level, thus contributing to shrinkage and felting.

If the blankets are not particularly soiled, and a high suds level is not maintained, more soap can be added without draining the machine. Otherwise, it is better to drain the machine and run in a new suds. This process should be repeated, depending upon the degree to which the blankets are soiled. The blankets are washed in each suds for ten minutes.

Then, depending upon the size of the load, the blankets are rinsed three or four times in water of the original temperature. The duration of each rinse should be from one to two minutes. An antiseptic sour is used in the last rinse water; this treatment disinfects and mothproofs the blankets, leaving them soft and odorless.

At this time it should be stressed that whenever the machine is drained

How to Avoid Shrinkage, Felting and Matting

1. Use soft water for suds and rinses.
2. Maintain a constant water temperature.
3. Use a low titer soap and maintain a high suds level at all times.
4. Be sure that the washing machine is standing still during the process of draining and refilling.
5. Extract woolen blankets for only one half minute.
6. Card blankets while they are still damp.
7. Dry slowly at the original temperature.
8. Do not leave blankets lying in the basket while wet.

Presented at the Minnesota Hospital Association convention, May 1944.

and refilled, it should be standing still; if the machine is left in motion during this process, shrinking and felting will result.

After the blankets have been removed from the washer, they should be extracted for a period of only one half minute—prolonged extracting is another cause of shrinkage and felting. Also, the blankets should be taken care of immediately and never be allowed to remain in a basket for any length of time before drying. If it is impossible to dry them at once they should be carefully folded.

The drying process can be accomplished in several ways, but perhaps the most satisfactory is by means of a blanket drying cabinet, which contains a high-speed fan. The blankets are placed on stretchers and reshaped to their original size. While they are still damp, they are carded—either by machine or by hand— and are then placed in the drying cabinet.

At this time it would be well to mention that during the drying process the air temperature should not exceed that of the water in which the blankets were washed. Woolen blankets should never be dried rapidly in a high temperature, for this is still another cause of shrinkage and felting—the two things it is so important to avoid.

If a drying cabinet is not available, and the blankets are dried on poles, they should still be carded while they are damp. The carding eliminates matting and restores the blankets to their original soft smoothness.

If blankets are well cared for they will render a long life of service and will retain their original soft smooth texture.

Cleaning Kits Save Steps

The appearance of the housekeeping cleaning kits used at Emory University Hospital, Emory University, Ga., is much the same as that of a carpenter's tool kit. They are made of scrap lumber and measure 9½ inches wide, 6½ inches deep and 27 inches in length. The ends of the kits are made to extend upward about 6 more inches, making the end pieces 12 inches high, in order that a piece of wood may be fitted to the top of each end piece and used as a handle. A broomstick cut to fit is good for this purpose because the round wood is easier and more comfortable to use as a handle than is wood that is angular.

Each kit contains the following equipment: a 12 ounce bottle of scrub soap, a 12 ounce jar of scrub powder (for bathroom floors), an 8 ounce bottle of furniture polish, a small can of cleanser, one putty knife (for removing chewing gum from floors), a radiator brush, a toilet brush, a scrub brush, a dustpan and brush, clean rags and a dust mop.

The kits are numbered individually, from 1 through 13, which is as many as we have at the present. They are kept in one room, and each girl doing the cleaning knows which is her kit. For example, the housekeeper checks a girl as having kit No. 4 and notes which floor she will be on. At the end of the day, when the kits are brought back, the housekeeper checks to see if everything is in its proper place in the kits. One girl has the responsibility of seeing that each kit is correctly equipped each morning.

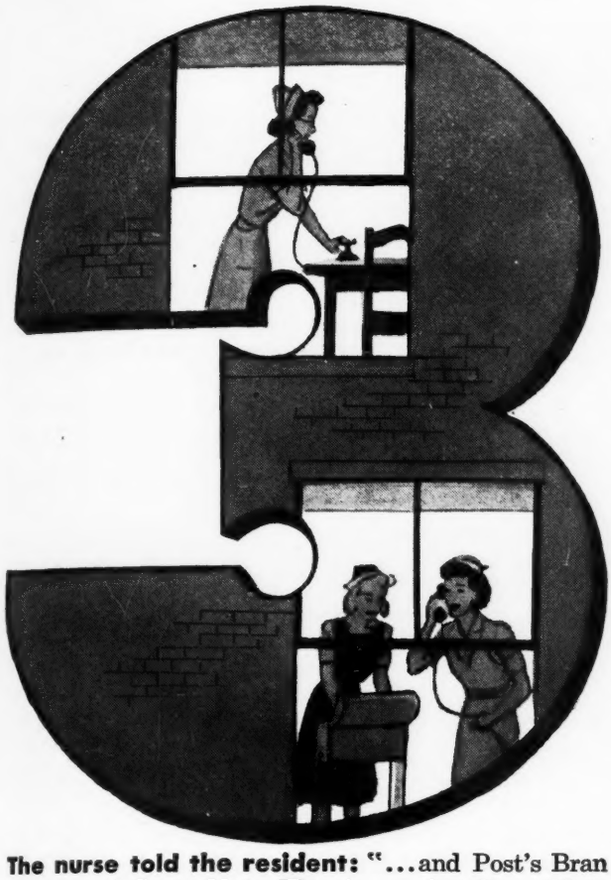
Having all the necessary equipment together in a kit enables us to save many hours on the time of the job, and another important advantage is that this method makes it possible for us to keep an accurate and constant check on our equipment.—Mrs. Loula Woodall, *executive housekeeper, Emory University Hospital, Emory University, Ga.*

The patient told the nurse's aid: "Why, practically everyone we know serves them at home. We heap fresh fruit on them . . . drown them in pasture-fresh cream . . . and they taste like honey-flavored chopped-sunbeams!"

The nurse's aid told the nurse: ". . . and as long as they're on her diet anyhow, why can't she have the cereals she serves at home? There are so many kinds, too. . . . Grape-Nuts Flakes, and Post Toasties . . ."

The superintendent told the dietitian: ". . . have switched to these General Foods Cereals, and that they come in individual-serving sizes, or great big economy boxes. So I thought perhaps we could try them . . ."

The dietitian told the superintendent: ". . . I wouldn't be much of a dietitian if I didn't know all these things—and I've already ordered General Foods Cereals! We start using them tomorrow!"



The nurse told the resident: "...and Post's Bran Flakes, and Grape-Nuts. There's even hot Grape-Nuts Wheat-Meal, you see. And they are full-cram-jam with crackling B_1 energy . . ."

The resident told the superintendent: ". . . and rolling-rich with the very whole-grain nourishment recommended in the Government's 'Basic 7 Foods Program!' What's more, I understand that hospitals all over the country . . ."

The patient told the world!

General Foods Cereals

GRAPE-NUTS • POST'S 40% BRAN FLAKES
POST TOASTIES • GRAPE-NUTS FLAKES
hot GRAPE-NUTS WHEAT-MEAL

Serve 'em the kind they eat at home!

NEWS IN REVIEW

Army Faces Critical Shortage of Nurses; Effort Made to Obtain 4000 by October

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Army is faced with a critical shortage of registered nurses, the War Department announced August 31. An effort to procure 4000 by October 1 has been in progress. The procurement is pointed at the nurses recently classified by the War Manpower Commission as available for military service.

State quotas for Army and Navy nurse corps recruitment for the period ending Dec. 31, 1944, were released by state committees of procurement and assignment early in August. W.M.C. said that state quotas were to meet the increasing demands of the armed forces for nursing services.

Following the War Department's announcement, the chairman of the War Manpower Commission instructed the Procurement and Assignment Service to request hospitals and physicians throughout the country to assist in the recruitment of nurses. About 29,300 student nurses are being graduated this year; of these some 9000 are needed for service with the Army and Navy. Of a class of 28,816 graduated last year, fewer than 5000 entered the armed forces for nursing service.

The following order of nurse use to assure that their services will be available on the highest professional level has been suggested:

1. Nurses who can be spared from essential civilian services should volunteer at once for service with the Army or Navy.
2. Nurses who are employed in nonessential work should transfer to essential nursing services.
3. Civilian users of nursing services, including hospitals, physicians and patients, should share all of the available nursing service according to the greatest need.
4. Inactive nurses, especially those who live in outlying communities in which there are serious shortages, should return to duty.

To Survey Costs of Nursing Schools

WASHINGTON, D. C.—The inauguration this fall of a cost study survey among a selected group of nursing schools was announced on September 12 by Dr. Thomas Parran, surgeon general of the U. S. Public Health Service.

"This is not an audit of expenditures from federal funds," the surgeon general said, "but an attempt to obtain accurate data on the actual cost of nurse education."

Dr. Louis Block, special consultant, hospital facilities section, U.S.P.H.S., has been named as cost analyst. He will visit more than 50 schools of nursing representing a variety of sizes, types of control and programs. He will confer with directors of these schools, hospital administrators and nurses in charge of various hospital units and will examine records of costs.

Information gained from this study will be used by the Division of Nurse Education for guidance in operating the U. S. Cadet Nurse Corps program and by the schools and hospitals in planning their individual programs.

Rapid Treatment Centers of Limited Value to Cadets

WASHINGTON, D. C.—A six months' assignment to Rapid Treatment Centers is not considered desirable for senior cadet nurses, because the experience, however valuable, is highly specialized and does not offer great variety, Lucile Petry, director, Division of Nurse Education, U.S.P.H.S., said August 29 in answer to inquiries.

An experience of a few days to one month, preferably two weeks, probably would be valuable either to junior cadets (on an affiliation basis) or to senior cadets, Miss Petry advised.

It could well be included in the plan for senior cadets who are remaining in the home hospital or who are assigned to near-by institutions. It could be advantageously coordinated with or included in an experience with a public health nursing agency, she concluded.

Tropical Disease Center in North Carolina

WASHINGTON, D. C.—Moore General Hospital at Swannanoa, N. C., was opened September 1 by the Army Medical Department as a special treatment center for malaria and other tropical diseases. The hospital has 350 beds for patients undergoing treatment and barracks facilities for more than 1000 men participating in a reconditioning program. Though particular study will be made of malaria and filariasis, the intention is to concentrate all patients suffering from tropical diseases at the new center.

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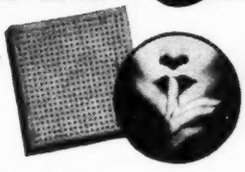
Perforated  *Fibre Tile* SINCE 1923

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Commission to Study New York Medical Care

A sixteen man commission has been appointed by Gov. Thomas E. Dewey to study medical care in New York State and formulate a program to be submitted to the legislature when it meets next January.

Announcements regarding the work of the commission have stated in one place that it is to be concerned with "medical care for those unable to provide it" while in quoting Governor Dewey the announcements have stated that it will cover "programs for medical care for persons of all groups and classes in the state of New York."

The commission has an appropriation of $40,000 for its work. The chairman is Dr. Basil C. MacLean, past president of the A.H.A. and of the A.C.H.A. and director of Strong Memorial Hospital, Rochester, N. Y. Doctor MacLean has just been put on a reserve basis following an assignment with the surgeon general of the U. S. Army. Other members are:

Dr. George MacKenzie, physician in chief, Mary Imogene Bassett Hospital, Cooperstown; Dr. Herman G. Weiskotten, Syracuse; Rev. John J. Bingham, assistant secretary of Catholic Charities of the Archdiocese of New York; Dr. Lucien Brown, Sydenham Hospital, New York City; Garrard B. Winston, New York City, former undersecretary of the Treasury; Ruth Hall, state chairman of procurement and assignment for the New York State Nurses' Association; Agnes Gelinas, professor of nursing of Skidmore College of Nursing; Marion Sheehan, director of the division of public health nursing of the state department of health.

Ex officio members and those representing the legislature are the commissioners of health, welfare and mental hygiene, Senators Lester Baum and Lazarus Joseph and Assemblymen Lee B. Mailler and Leonard Farbstein.

Latin-American Specialists Study in United States

More than 300 physicians, nurses, sanitary engineers, hospital administrators and other public health specialists from the other Americas were receiving or had completed advanced training in the United States in the year ending in June 1944, according to an announcement by the Institute of Inter-American Affairs on September 12. They came on study grants, usually one year fellowships in recognized institutions of learning, or to work with professional leaders. Many have been assigned to hospitals for special research. The five year program is designed to bring an average of 120 trainees a year to the United States.

Government restrictions eased on heavy duty equipment for mass feeding

• In line with its recognition of the importance of efficiency in mass feeding, the government has considerably relaxed restrictions on heavy duty cooking equipment. Accordingly it is now possible for cafeterias, restaurants, hospitals, schools, hotels and other institutions engaged in mass feeding, to obtain equipment if it is needed.

Adequate facilities for proper food preparation are essential to the maintenance of approved standards of nutrition. These standards must be maintained in order to protect the health and energy of war workers. And in this total war, every loyal citizen *is* a war worker.

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War Department Outlines A.S.T.P. Medical Program

By EVA ADAMS CROSS

WASHINGTON, D. C.—Procedures for disposal of certain enlisted personnel in the Army Specialized Training Medical Program were announced in August by the War Department. The Military Appropriations Act, approved June 28, 1944, which stipulated that none of the funds appropriated should be used for training medical and premedical students unless they were in training prior to June 7, 1944, and unless such training was defrayed from 1944 appropriations is given as the necessity for these procedures.

Those individuals now on active duty whose medical or premedical educational expenses were defrayed in whole or in part by the government under the A.S.T.P. program prior to June 7 will be continued in the medical program of the A.S.T.P. Those on active duty whose medical or premedical training was not defrayed either in whole or in part prior to June 7 will be disposed of as follows:

1. Those who have letters of acceptance and who would have entered an accredited medical school by Dec. 31, 1944, may elect to be discharged from the Army shortly before the entrance date of the class for which they were accepted or to be assigned to the Medical Department with no further A.S.T.P. training.

2. Those who do not have a letter of acceptance to an accredited medical school by Dec. 31, 1944, will be continued on active duty and will not be eligible for medical training under the A.S.T.P.

A.H.A. to Conduct Purchasing Institute

The third institute on hospital purchasing will be conducted by the committee on purchasing of the A.H.A. at the Knickerbocker Hotel, Chicago, from November 13 through 17. The program will deal with both war-time purchasing and postwar conditions.

Morning sessions will be devoted to lectures on the theory and practice of purchasing and the organization of the purchasing department. Afternoon seminars will consist of open discussion on the purchasing of specific commodities.

Evening round tables are to answer questions and specific problems. Adoption of correct purchasing procedures in small hospitals will be given special attention and one round table will be devoted wholly to this problem.

Demonstrations will include the grading of canned goods and the cutting of meat. The use of new materials developed by the war will be given special attention.

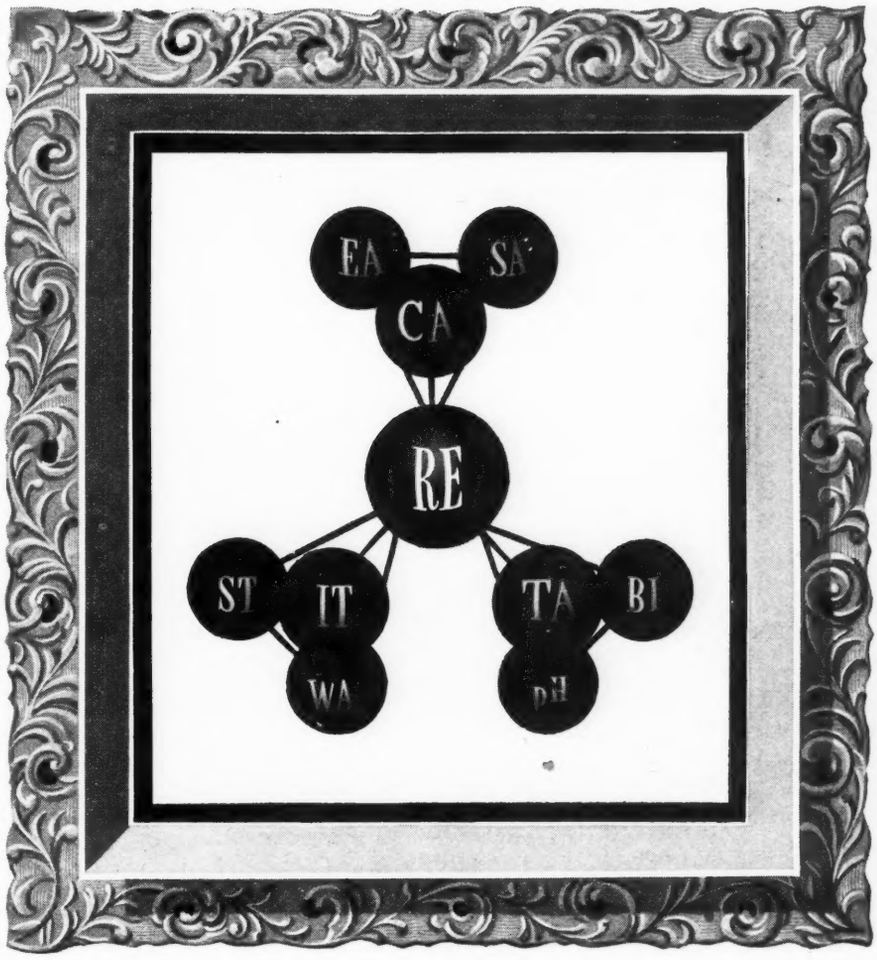
Speakers will include hospital authorities, commercial representatives and others from industry and various specialized fields.

Registration will be limited to 100. The fee is $20. Accommodations are available at the Knickerbocker Hotel for living as well as lecture and meeting rooms. Persons holding administrative positions in hospitals or having purchasing responsibility assigned to them wholly or in part are eligible to register.

Arden E. Hardgrove is to be director of the institute with F. Hazen Dick, associate director. The chairman of the committee on purchasing is Everett W. Jones.

Navy Nurse Uniform Modified

WASHINGTON, D. C.—At overseas hospitals in which laundry facilities are limited, officers of the Navy Nurse Corps, subject to approval of the commanding officer, may now wear the basic seersucker gray and white striped dress of the Women's Reserve, according to an order of August 22 by Capt. Sue S. Dauser. This will be worn without tie and open at the neck with the same miniature devices as with the white duty uniform and with beige hose and black shoes.



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Petry Seeks Aid of State Nurse Boards

WASHINGTON, D. C.—In a memorandum sent September 8 to state boards of nurse examiners concerning the senior cadet period and some of its implications, Lucile Petry, director, Division of Nurse Education, U. S. Public Health Service, emphasized the importance of the boards.

It will be helpful, she pointed out, if the state boards will discuss nursing needs with schools of nursing, communicable disease hospitals, tuberculosis hospitals, public health agencies and others and then recommend plans for senior cadets. State boards will help others if they will encourage schools with good plans to publish them.

State boards should prepare lists of civilian hospitals, other community agencies and federal hospitals that desire to use senior cadet nurses and are approved by the state board, Miss Petry suggested. They should forward this information to the State Board Clearing Bureau, American Nurses' Association, New York City, for distribution to other state boards. The acceptance by state boards of recommendations made by other state boards would facilitate assignment of senior cadets to institutions or agencies outside their own states, particularly in the case of federal nursing services, she said.

The state board is also responsible for guaranteeing that the cadet will receive experience which, upon graduation, will permit her to take board examinations, Miss Petry emphasized.

That the basic educational programs of senior cadets have been accelerated and are complete should be realized by schools, state boards, institutions and other agencies using the services of these students, the director continued. They should give proper recognition of the fact that a senior cadet released from formal study can make almost the contribution of a full-fledged graduate nurse.

Thoughtful planning and careful consideration of needs of others should result in wise distribution of an increasing amount of nursing service and should enlarge the scope of experience of the 24,000 students who will become senior cadets between July 1, 1944, and June 30, 1945.

Kettering Joins Commission

Charles F. Kettering, noted engineer and inventor and vice president of General Motors Corporation, has accepted membership on the Commission on Hospital Care, the new study group started by the A.H.A. which is under the general chairmanship of Thomas F. Gates. Mr. Kettering is a trustee of Miami Valley Hospital, Dayton, Ohio.

Psychology of Color

SOLARIUM

THE PROBLEM: This room is used on gray and overcast days as well as when the sun shines. Should be cheerful at all times.

THE SOLUTION: The solarium will be always sunny in appearance when painted Sunlight Yellow (Wallhide Intermix No. 3).

LINEN ROOMS

THE PROBLEM: Hospital linen takes a beating . . . is sterilized so much it takes on a yellow cast. This creates an unfavorable impression on visitors who inspect the linen room.

THE SOLUTION: Linen will look whiter when cabinets and shelves are painted in Waterspar Delphinium Blue.

LABOR ROOMS

THE PROBLEM: In these small rooms, patients often suffer from a feeling of claustrophobia.

THE SOLUTION: The lower third of the wall should be painted in Palace Guardroom Green, the next third in a lighter shade of the same color, and the top third in a still lighter shade. These horizontal stripes in receding tones will make the walls visually widen out.

"DOCTOR," we said to the superintendent of a large west coast hospital, "this room must have a psychological effect on a patient that's roughly equivalent to what a dull rainy day in late autumn does to you."

"On what do you base that statement?" he asked.

We pointed out that the brown linoleum floor was the color of dead leaves and the grey walls were the exact tone of an overcast sky.

"One of the principles of COLOR THERAPY," we continued, "is that every color has its basic association. White suggests the coldness of winter—grey a cloudy horizon—brown a frostbitten landscape. Instead of these, we use green (nature's rest color), the light blue of a clear sky, the rose of a lovely sunset, and the yellow of bright sunlight. Each is a COLOR SPECIFIC chosen to evoke favorable psychological reactions from your patients and staff."

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Pennsylvania Administrators Learn Value of Good Public Relations

By RAYMOND P. SLOAN

Despite vacation periods, the war and unsettled conditions generally, the Hospital Association of Pennsylvania took time off on August 25 and 26 to think about and discuss hospital public relations. In State College there was held, in cooperation with the extension service of Pennsylvania State College, what is believed to be the first institute on this subject. The response was significant—130 registrants representing 80 hospitals, plus four Blue Cross Plans.

Practically every phase of hospital public relations was covered during the two day sessions by people within and without the hospital field. Hospital superintendents described their problems and recounted their progress. Press representatives, journalists, editors, psychologists, public relations directors and printers stated frankly what they believed to be wrong with the way in which the hospital story is being told and made suggestions for its improvement.

To the question, "Why a Public Relations Program?" Louis H. Bell, director of public information, Pennsylvania State College, replied: "Public relations is simply a way of putting our best foot forward. Or to use a more formal description, it's the method by which you make your activities, ideas and philosophies understandable to the public you are trying to serve in order that the public will recognize you, accept you and help support you. It becomes fairly obvious, therefore, that hospitals need good public relations because they need public support from the city, the county and the state. Such support comes only with confidence. And confidence is a natural by-product of good public relations."

From the point of view of the psychologist, the first step in any public relations program should be a clear statement of objectives or goals. "Just exactly what do you want people to think and what do you want them to do? It is not enough to state goals in generalities. If I were the director of a public relations program," said Stanley Gray, professor of psychology, University of Pittsburgh, "I would appeal to every human want which was in any way related to my institution."

Before embarking upon any public relations program, the hospital should check first to see that its house is in order, that it has something to talk about. Personnel and family relations, in other words, must come logically before public relations, according to Raymond P. Sloan, editor, The MODERN HOSPITAL.

The need for good press relations was emphasized repeatedly. Hugh Wagnon, chief of the Associated Press for Pennsylvania, described press relations as easy to obtain and still easier to maintain. "It involves," he said, "simply the application of the Golden Rule and recognition of the fact that the press and the hospital are striving to serve the public, each in its own field. If your press relations is bad, your public relations cannot be good. If your press relations is good your public relations must be better than would otherwise be possible."

Public relations is a full-time job in many hospitals. Ellen Petts Marcosson, director of public relations, Memorial Hospital for Cancer and Allied Diseases, New York City, should know for she has held such a job for many years. Her office of public relations works directly under the committee on public relations of the board of managers.

"The liaison officer between the board and my office," Mrs. Marcosson explained, "is the chairman of the committee on public relations of the board. Members of the public relations committee are active businessmen and bankers deeply interested in the hospital, applying, insofar as practical, business managerial methods to hospital administra-

tion. Equally important is my contact with the director of the hospital, also the hospital superintendent and the department heads. Good public relations is based on high quality of service to the community, which to a great degree depends on good inter-institutional relations."

Illustrations play an important part in telling the hospital story provided they are properly handled. John B. Watkins, president of John B. Watkins Printing Company, New York City, warned that a close relationship should exist between the editorial purpose and the photograph. The picture should not be selected solely on the basis of a dramatic scene or a "cute" baby. It should have editorial content; it should show people and not empty rooms or mechanical equipment, which are sterile of human interest. For a key picture the greatest effectiveness may usually be achieved by showing the "end product," that is, the hospital's function in its final state when human happiness results.

Speaking from the standpoint of the hospital administrator, Carl I. Flath, administrator, Charlotte Memorial Hospital, Charlotte, N. C., expressed the opinion that "individually and collectively hospital people have done an exceedingly poor job of interpreting themselves and their activities to the public; that hospitals have said too little of their accomplishments and importance to the world we live in, leaving the common man—who might yet have to decide the future form of operation of hospitals—with some reservations and misgivings as to whether or not hospitals have, by their own devices, done a great deal after all. . . . Social modification in many fields, including that of hospitals, is to be expected, but better public relations practiced now can affect its degree and final form."

Also presenting the hospital's point of view in the discussions were Louis C. Trimble, superintendent, Adrian Hospital Association, Puxsutawney; E. Atwood Jacobs, superintendent, Reading Hospital, Reading, and M. H. Eichenlaub, superintendent, Western Pennsylvania Hospital, Pittsburgh.

Army Sets Up Psychiatric Centers

WASHINGTON, D. C.—A program of reconditioning to prepare neuropsychiatric patients for return to duty as soldiers or return to civilian life in the best possible physical and mental condition was announced in August.

Men suffering from such disturbances will participate in carefully organized convalescent activities under the guidance of trained psychiatrists. Schedules will include physical reconditioning and occupational, educational and recreational therapy.

At least one hospital in each service command will be designated as a neuropsychiatric reconditioning center. The following have been selected: Lovell General Hospital, Fort Devens, Mass.; England General Hospital, Atlantic City, N. J.; Fort Story, Va.; Welch Convalescent Hospital, Daytona Beach, Fla.; Wakeman General Hospital, Camp Atterbury, Ind.; Percy Jones General Hospital, Battle Creek, Mich.; Camp Carson, Colo.; Brooke General Hospital, Fort Sam Houston, Tex., and Mitchell Convalescent Hospital, Camp Lockett, Calif.

St. Louis Sets Nurses' Salaries

Standard salaries for general duty hospital nurses in St. Louis should start at $150 per month and deductions for maintenance should be $30 for meals, $15 for room and $7.50 for laundry. These were recommendations approved by the Hospital Council of St. Louis based on a report of a special committee headed by C. E. Copeland. Any work beyond eight hours in one day is to be paid for at regular hourly rates. Special duty nurses asked to serve for a short time on floor duty are to receive 75 cents per hour.

Surplus Property Bill in Committee

WASHINGTON, D. C.—H.R. 5125, an act to provide for the disposal of surplus government property and plants, passed the House August 22 and is at present in a conference committee of the two houses for the ironing out of differences. Section 12 of the Act declares that "(b) Surplus medical supplies, equipment and property suitable for use in the protection of public health, including research, may be transferred to the Federal Security Administration for donation to the states and their political subdivisions, including municipalities, and to tax-supported medical institutions, and, within rules and regulations to be prescribed by the Federal Security Administrator, with the approval of the board, to hospitals or other similar institutions not operated for profit which have been held exempt from taxation under section 101(6) of the Internal Revenue Code, and to the American Red Cross."

Surplus property may be sold or leased to nonprofit charitable, medical and educational institutions at discounts not to exceed 50 per cent of the sale or lease market value thereof or 50 per cent of the highest price offered by any private purchaser or lessee, whichever is lower, provided that other surplus property not immediately disposable for which the estimated cost of care and handling and disposition would exceed the estimated proceeds of commercial disposition may be donated to states, political subdivisions thereof . . . and, within rules and regulations prescribed by the board, to . . . nonprofit, charitable, medical and educational institutions.

Menninger Clinic Opens Research Laboratory

A new laboratory for research in hypnosis, the third building in the rapidly growing plant of the Menninger Foundation, was opened in August at Topeka, Kan. The foundation, which is three years old, has received more than $88,000 in its program to make Topeka a center for research and education in neuropsychiatry. The foundation has a carefully chosen membership of 75 leaders in the field of psychiatry and psychoanalysis.

The U. S. Public Health Service has requested the school of nursing to direct its efforts to the preparation of teachers of psychiatric nursing. The foundation also hopes to enlarge its program of teaching clinical psychologists, social workers and therapists.

The new building contains 15 offices, a classroom and a reception room; these are for use not only of the research department but of the administrative and teaching departments of the foundation.

W.P.B. Approves 107 New Projects

A total of 107 hospital building projects was given approval by the War Production Board in the period from July 17 to September 9. The projects involving more than $100,000 of total value are as follows:

Houston, Tex.—New hospital for Negroes for St. Elizabeth Hospital, $105,200.

Lebanon, Pa.—New hospital for the Veterans Administration, $2,943,000.

Morehead City, N. C.—Thirty bed addition to Morehead City Hospital, $168,100.

Owensboro, Ky.—New building to house 55 patients and 25 Sisters and nurses, $315,000.

Columbus, Ohio—Doctors' Hospital addition and laundry and boiler room building, $118,500.

Louisville, Ky.—Addition to nurses' home of St. Joseph Infirmary to contain 44 double rooms and 10 rooms for supervisors, $268,225.

Los Angeles—Addition of 117 adult beds and 103 bassinets to Queen of Angels' Hospital, $607,495.

Alton, Ill.—Additional nurses' housing and educational facilities for Alton Memorial Hospital, $100,436.

Clintonville, Wis.—New 35 bed hospital building for Clintonville Community Hospital, $200,200.

Peoria, Ill.—Addition of three stories and part basement to nurses' home for St. Francis Hospital, $201,685.

Beaver Falls, Pa.—Five story addition to provide for 38 additional patients at Providence Hospital, $225,000.

Ahoskie, N. C.—New hospital to provide for three farming counties to be called Roanoke-Chowan-Ahoskie Hospital, $240,000.

Detroit—New 100 bed addition to Outer Drive Hospital, $883,600.

Huntington, W. Va.—Additional five story wing and two more stories on present building of St. Mary's Hospital, $210,000.

Huron, S. D.—New nurses' home and service building for St. John's Memorial Hospital, $414,100.

Ogden, Utah—New 150 bed hospital and 110 bed nurses' home for the Sisters of the Order of St. Benedict, $1,189,900.

Fort Meade, S. D.—Alterations to convert permanent buildings at a former military reservation into a Veterans Administration hospital, $3,000,000.

Norristown, Pa.—New ward building for mentally ill male patients at Norristown State Hospital, $839,788.

Durham, N. C.—New buildings for housing animals and addition to storage building at Duke University Hospital, $110,000.

Alexandria, La.—Sixty-six bed and four bassinet addition to Murrell Clinic and Hospital, $135,410.

Monroe, La.—Fifty bed nurses' home for St. Francis Sanitarium, $183,500.

Eloise, Mich.—Two story health and clinic building for Wayne County Health Center, $134,724.

Newnan, Ga.—Addition to Newnan Hospital to add 34 beds, $125,000.

Minneapolis—Five story addition and remodeling of kitchen and dining rooms at the University of Minnesota Hospital, $385,000.

Washington, D. C.—Addition to provide 22 beds for private and semiprivate patients at Children's Hospital, $143,000.

Blue Cross Issues Statistics Experience

The Blue Cross plan directors' "Blue Bible," the annual volume of Blue Cross statistics entitled "Experience of Blue Cross Plans," was mailed out on September 5 by the Hospital Service Plan Commission.

In introducing the volume the committee on statistics states that "the introduction of the proposed amendments to the Social Security Act necessitates a reevaluation of the scope of our service to the community and an examination of the possibilities of increasing that service at about present subscription cost levels.

"The postwar reconversion period and subsequent redistribution of employment will create another problem, which must be considered now. The cost of handling conversions from pay roll to direct payment groups and the effect of these conversions on experience require careful study, if we are to continue our successful operations at the cessation of hostilities.

"The effect of comprehensive service on the incidence of admissions and the number of days provided in a contract and its effect upon the length of stay per case need critical examination during the period when many of us are considering broadening our subscriber contracts."

The statistical tables were prepared by Maurice J. Norby.

R.N.'s Get Special Training for Essential Positions

WASHINGTON, D. C.—The Division of Nurse Education, U. S. Public Health Service, is inaugurating a program of intensive special courses to relieve the critical shortage of personnel in strategic positions, according to Lucile Petry in an announcement August 30. The program will be carried out in conjunction with university centers, state boards of nurse examiners, state departments of public health and other interested groups.

The new intensive short courses will be functional rather than academic in nature. They are planned for clinical instructors and supervisors, assistant clinical instructors and head nurses and for other administrative, teaching and supervisory personnel in greatest need of special preparation in given areas. They will not supplant well-established programs now already approved for federal funds in universities.

Federal funds through the Bolton Act are available to cover the instructional cost fee for each graduate nurse who enrolls, and maintenance in certain cases.

The first step in the new program will be the preparation of special "trainers," intensive courses for whom are already in progress in more than 12 large university centers. These courses will continue until at least 400 graduate nurses have been prepared. Upon the completion of their special preparation, the trainers will return to designated areas and conduct for local groups one or more of the following types of intensive short courses—extramural, condensed or course by a circulating teacher.

Extramural courses will be conducted in centers where graduate nurses from several institutions and agencies come together once a week or more often for one class period of one or more hours in the afternoon or evening. They will extend from six to sixteen weeks.

Condensed courses are those conducted in a center by a trainer for from one to six weeks of concentrated full-time study.

The course taught by a circulating teacher is designated for those nurses who may not obtain brief leaves of absence. The circulating teacher will spend one half day to three days in an institution or agency (or combination of adjacent institutions) and will circulate to other institutions as her time allows.

Parran Continues to Urge National Health Plan

Dr. Thomas Parran, surgeon general of the U.S.P.H.S., carried on his campaign for the development of a national health program in an address during the dedication of the new nurses' home at the University of California School of Nursing in San Francisco on September 4.

The surgeon general proposed a national health program that would include adequate, inter-related and equitably distributed hospital and medical service, greatly expanded preventive services, sanitary facilities and control of mass disease. The plan would be operated locally through grants-in-aid and would be sufficiently diversified to meet the needs of the individual states. It would be supported through insurance, taxation or a combination of both.

"The hospital of the future should be an instrument of total community health with the facilities and skills necessary to promote health and prevent disease, as well as to treat the sick," Doctor Parran stated. He said that his proposed program would not be entirely socialized or entirely private but a combination of both.

First-Aid Poster Issued

A poster on first aid approved by the Philadelphia County Medical Board and the local department of public health is being widely distributed through its area by the Associated Hospital Service of Philadelphia. A recent wide distribution was accomplished when the Pennsylvania Hospital enclosed copies of the poster with its hospital bulletin.

A.C.H.A. Institute Draws Record Attendance

The increasing interest among hospital executives in institutes and summer courses was demonstrated by the excellent attendance at the two Cornell University summer courses (one for hospital administrators and one for institutional housekeepers) and at the American College of Hospital Administrators' institute held at the University of Chicago September 11 to 23. Attendance at the A.C.H.A. institute totaled 127 and it was necessary to refuse admission to 46 prospective students.

Special emphasis was placed at this institute on the importance of hospital accounting. A series of lectures on this subject was presented by William Vatter, associate professor of accounting, school of business, University of Chicago.

Two new features were inaugurated at this institute. One was the early morning conferences which were held from 8 to 8:50 each morning preceding the regular class periods. The second innovation was the four post-institute study tours which were arranged for the week of September 25 to 30. Visits were made to the W. K. Kellogg Foundation Hospitals in and around Battle Creek; the University of Michigan Hospital, Ann Arbor, and to selected hospitals in Detroit. The tours wound up with the meeting of the American Protestant Hospital Association in Cleveland and a demonstration at St. Luke's Hospital.

Discussion of all important topics of hospital administration and inspection trips to local institutions occupied the time and attention of the 20 students who attended the two week refresher course in hospital operation given at Cornell University by Dr. Joseph C. Doane and Dr. Donald C. Smelzer. Each member of the class presented a thesis on a subject of particular interest to him and these papers became the topic for general discussion.

Eighteen students attended the Cornell summer course in institutional and professional housekeeping conducted by Mrs. Adele B. Frey, housekeeping consultant and former executive housekeeper of the Stevens Hotel in Chicago. Subjects covered during the course included: textiles and linens; spring and mattress construction; blankets; maintenance of floors, floor coverings and upholstered furniture; modern decoration with drapery and upholstery fabrics.

La Guardia Health Plan Filed for Incorporation

Application for incorporation of Mayor La Guardia's health plan for workers was made on September 4. The plan is designed for all persons living or working in New York City and not earning more than $5000 annually. It is expected that the plan will be ready for operation by January 1 and that most of the city's 190,000 employes and many union members will enroll promptly.

Incorporators include Henry J. Kaiser, West Coast shipbuilder; Former Governor Alfred E. Smith; Beardsley Ruml, chairman of the board of the Federal Reserve Bank; Gerard Swope, chairman of the board of General Electric Company; Sidney Hillman, president of the Amalgamated Clothing Workers Union; Wendell L. Willkie, and the borough presidents.

On September 8 Mayor La Guardia told reporters that he would be "for" the health insurance plan of the United Medical Service, Inc., which is approved by the state medical society and is now enlisting physicians' participation, if it would offer coverage for the entire family. The United Medical Service is the result of the merger of Community Medical Care and the Medical Expense Fund of New York. The Associated Hospital Service handles sales for United.

It is expected that new contracts may be available in October embodying family coverage.

South Carolina Starts Nurse Training Program

South Carolina will start a four year statewide collegiate nurse training program this fall under the direction of the state university at Columbia leading to a diploma in nursing and a B.S. from the university. Students will spend sixteen months at the university and the remainder of the time in affiliated hospitals and health agencies.

Viana McCown, director of nursing education at Columbia Hospital, has been given an indefinite leave of absence to serve as director of the department of nursing at the university, which has been organized as a division of the college of arts and science. Approximately 50 students already have been accepted for the November term.

The program was developed with the assistance of Ruth Sleeper, president of the National League of Nursing Education and special consultant to the U.S.P.H.S.

At present the university has affiliations only with Columbia Hospital but plans are to include other hospital schools throughout the state.

Miss McCown received her nursing education at Pennsylvania Hospital and Columbia University. Before moving to Columbia in 1941 she was with Cook County Hospital School of Nursing, Chicago, and the University of Cincinnati School of Nursing.

A.M.A. Will Support Industrial Health Plan

WASHINGTON, D. C.—Speaking for the American Medical Association, Dr. Carl Peterson, secretary of the Council on Industrial Health, said that the association would support federal legislation to provide industrial medical services for all federal employes, who now total about 2,700,000.

The plan was proposed by Surgeon General Parran in hearings before the house district committee on August 21. It includes a good preemployment examination, including a chest x-ray, minor medical and dental care, minor care for emotional disturbances, a nutritional program, checks on environmental sanitation and working conditions, studies of sickness records, control of contagion and infection and some routine care in pregnancy.

Doctor Parran estimated the cost at less than 1 cent per employe per day. Employes needing major care would be referred to private physicians.

Doctor Peterson stated that the program should follow sound standards of industrial medicine and should include workmen's compensation cases.

It's "Dicumarol" to All

For the first time pharmaceutical manufacturers have agreed to use the same name, rather than different trade names, for a product. All the various licensees —Abbott Laboratories, Eli Lilly and Company, E. R. Squibb & Sons and Ayerst, McKenna and Harrison—are using the name "dicumarol," the registered collective trademark adopted by the Wisconsin Alumni Research Foundation. Dicumarol is an effective anticoagulant, having a delayed and cumulative effect. It is especially useful in the treatment of postoperative, posttraumatic and postinfectious thrombophlebitis, pulmonary embolism, acute embolic and thrombotic occlusion of peripheral arteries and recurrent idiopathic thrombophlebitis. Since overdosage may result in severe hemorrhage, the prothrombin time must be determined each day as a control.

Adds 18 More Beds

An 18 room annex is being constructed at Stephenville Hospital, Stephenville, Tex. The construction will be completed in about two months.

ABOUT PEOPLE

(*Continued from page* 81)

Mann, superintendent of nurses at Vallejo Community Hospital, Vallejo, Calif.

Edyth Barnes, director of the school of nursing, Grace Hospital, New Haven, Conn., resigned on August 15 to accept a position with the U. S. Public Health Service. **Peggy Stewart,** assistant director, has been named to succeed Miss Barnes as head of the nursing school.

Miscellaneous

Frank L. Bosquet, assistant director of the Salem Hospital, Salem, Mass., has accepted foreign duty with the United Nations Relief and Rehabilitation Administration.

E. P. Lichty, formerly director of Hospital Service, Inc., Des Moines, Iowa, has resigned to become assistant director in charge of enrollment of the Chicago Plan for Hospital Care.

Dr. Victor H. Vogel, surgeon, U.S.P.H.S., has been appointed consultant in psychiatry to the Office of Vocational Education, and **Dr. Mark E. Gann,** also of U.S.P.H.S., has been appointed as assistant regional representative assigned to the San Francisco office. Doctor Vogel organized the blood and plasma programs for the O.C.D. He received training in psychiatry at Colorado Psychiatric Hospital and Johns Hopkins and is a diplomate of the National Board of Neurology and Psychiatry and a fellow of the American Psychiatric Association. For two years he was assistant chief of the Mental Hygiene Division of U.S.P.H.S.

Doctor Gann will assist the states in the western area in inaugurating physical restoration services. His previous work for U.S.P.H.S. has been in industrial surgery and in a medical care project in Mobile, Ala., for war housing clinics.

Maurice J. Norby, for the last five years the director of research for the Hospital Service Plan Commission, has been granted a leave of absence to work with **Dr. Arthur C. Bachmeyer** in the two year study of the Commission on Hospital Care. He began his new duties on October 1. He will direct the technical phases of the survey to be made by the commission. Before coming to the A.H.A. Mr. Norby was executive director of the Hospital Service Association of Pittsburgh from 1938 to 1939. Prior to that he was a member of the staff of the Minnesota Hospital Service Association.

Roy Hudenburg, a member of the *Hospitals* staff since last December, was appointed acting secretary of the Council on Hospital Planning and Plant Operation on September 15. In the course of his work during the year he has conducted for the Council on Government Relations the survey on postwar hospital construction and has been laying the groundwork for the forthcoming association directory of hospitals. His previous career centered around property management, real estate and construction in Chicago, culminating in his management of the Graemere Hotel for the five years prior to his coming to the association journal.

Col. William J. Bleckwenn, professor of neuropsychiatry at the University of Wisconsin, who has just returned from the South Pacific where he was commander of a medical regiment, has been appointed neuropsychiatric consultant of the Sixth Service Command, Chicago.

Maurice Packwood, formerly assistant

director of Cleveland City Hospital, has been added to the staff of the U. S. Bureau of the Budget.

Dr. Charles E. Clark, senior resident physician at State Hospital, Trenton, N. J., is the new assistant superintendent of Norwich State Hospital, Norwich, Conn., succeeding **Dr. Ronald Kettle** who is in military service. Doctor Clark has also served as a consultant in a private school for feeble-minded children and has conducted a child guidance clinic.

Dr. E. F. Kelly has resigned as secretary of the American Pharmaceutical Association. Doctor Kelly had been secretary of the association since 1926 and played an active part in food and drug legislation and the Pharmacy Corps Bill.

Boyden Roseberry, director of the medical department, Children's Aid Society, New York City, has resigned to become executive secretary of the Westchester County Medical Society, New York.

Brig. Gen. Charles C. Hillman, for five years chief of the professional service of the Office of the Surgeon General, has become commanding general of Letterman General Hospital, San Francisco. He succeeds **Brig. Gen. Frank W. Weed** who is retiring. The hospital has been designated as the chief debarkation hospital for casualties from the Pacific area.

Dr. Fredrick F. Yonkman has resigned as professor of pharmacology and therapeutics and chairman of the department at Wayne University College of Medicine, Detroit, to accept a position as chief pharmacologist in the research division of Ciba Pharmaceuticals, Inc., Summit, N. J. **Dr. Harold F. Chase,** assistant professor at the university, has resigned to accept a similar position at Western Reserve University School of Medicine, Cleveland, and **Bradford N. Craver,** research associate, has resigned to become instructor and director of pharmacologic research at the University of Rochester, N. Y.

Virginia M. Dunbar, deputy director of nursing service, American Red Cross, has been appointed director of nursing service, American Red Cross, following the resignation of **Mary Beard. Mrs. Dorothy W. Conrad,** formerly associate director of enrollment, American Red Cross, will succeed Miss Dunbar.

Deaths

Dr. Albert W. Buck, superintendent of Charlotte Hungerford Hospital, Torrington, Conn., died suddenly early in September. Doctor Buck served with the U. S. Public Health Service in the United States and Europe from 1913 to 1923, and was assistant director of Johns Hopkins Hospital, Baltimore, between 1924 and 1926. He was appointed superintendent of New Haven Hospital, New Haven, Conn., in 1926, where he remained until he became administrator of Charlotte Hungerford Hospital in 1937. He was a fellow of the American College of Hospital Administrators and served as president of the New England Hospital Assembly in 1935. In 1936 he was third vice president of the American Hospital Association and president of Connecticut State Hospital Association.

Coming Meetings

Oct. 25-27—American Dietetic Association, Palmer House, Chicago.

Oct. 30-31—National Society for Crippled Children, Inc., Edgewater Beach Hotel, Chicago.

Nov. 2-3—Maryland-District of Columbia Hospital Association, Lord Baltimore Hotel, Baltimore.

Nov. 13-17—A.H.A. Institute on Hospital Purchasing, Knickerbocker Hotel, Chicago.

Nov. 14-15—Kansas State Hospital Association, Wichita.

Dec. 3-16—Second Inter-American Regional Institute for Hospital Administrators, Lima, Peru.

1945

March 12-14—New England Hospital Assembly, Hotel Statler, Boston.

April 12-13—Texas Hospital Association, Galveston.

April 18-20—Hospital Association of Pennsylvania, Bellevue Stratford Hotel, Philadelphia.

May 2-4—Tri-State Hospital Assembly, Palmer House, Chicago.

May 23-25—Hospital Association of New York State, Hotel Pennsylvania, New York City.

OFFICIAL ORDERS

August 15 to September 15

Construction.—A few changes have been made in the construction order L-41, amended August 19. Under paragraph (c) which indicates how much construction is allowed without getting permission, the following sentence has been added: "If a utility connection (electric, gas, water or central steam heating) will be required, it may be necessary to get War Production Board approval for the connection."

Installation or relocation of machinery and equipment is discussed at some length in the amended order. Under certain specified conditions set forth in the order, it is not necessary to get W.P.B. permission to install a single piece or a group of related pieces of processing machinery or equipment (including used equipment) or machinery or equipment specifically rated or authorized by W.P.B. on a special form. Under specified conditions, too, W.P.B. permission is not required for relocation of machinery and equipment.

Cutlery.—Increased amounts of iron, steel and other metals may be used to make both lightweight and large heavy duty hand hair clippers, and aluminum is permitted for any type of cutlery, W.P.B. announced August 31 in amending the cutlery order, L-140-a. Aluminum is being used for handles on knives required by laboratories producing certain serums and vaccines and for guards on food-processing cutlery, as well as for numerous other purposes in cutlery manufacture.

DDT.—This new and potent insecticide has been exempted from price control since it is still used solely by the armed forces.

Dental Units.—Sharp declines in military requirements and acute shortages for civilian use have led the dental equipment advisory committee to recommend to W.P.B. that Order L-249 covering dental units and dental chairs be revoked. Manufacturers are holding heavy backlogs of unfilled orders.

Enamelware.—Production of several items of domestic and hospital enamelware may now be resumed through amendment of the enamelware order, L-30-b, August 23. The newly permitted items of hospital enamelware are: immersion arm baths, iodine cups, forceps jars, urinals and graduates. They are all controlled as to number of models and sizes. The permitted domestic items are: colanders, baby bottle sterilizers, dishpans, infants' bathtubs, funnels and baby chambers.

Food.—As a result of action taken August 17 in the amendment of RO 3, local ration boards may now act at once to prevent hardship when applications are received for supplemental allowances of rationed food for reasons of health. The amendment permits local boards to take limited action on applications for larger supplemental allowances than they are authorized to issue. Pending action by a medical panel, ration boards have authority to issue certificates in emergency cases to enable the applicant to get additional foods for a two-week period, even though the illness is not one of those on the approved list. Since some local boards have medical panels of their own, it is provided that a district office may authorize such boards to act on all applications for additional rations sought for reasons of health.

Hardware.—Restrictions on the use of aluminum and zinc in builders' finishing hardware, cabinet locks and padlocks and on the use of brass in essential working parts of cylinder locks were removed by W.P.B. on September 12.

Laundry Equipment.—W. S. Brines, chief of the hospital section, W.P.B., had a word of caution August 29 for hospitals requesting laundry equipment controlled by Order L-91. Do not fail, he urged, to provide the following information: (1) description of present equipment, giving sizes, type and age; (2) name of supplier and manufacturer; (3) cost of each item of equipment; (4) delivery date as ascertained from supplier.

Lighting Fixtures.—Restrictions on the use of metals in incandescent lighting fixtures of the utility type were removed August 16 from Order L-212 and minor relaxations affecting other types of incandescent lighting fixtures have been made. Chiefly affected by former restrictions of the use of metals in utility fixtures were reflectors and recessed fixtures. Utility fixtures are designed for use in hospitals, offices, stores and exit signs.

Lumber.—An extra 70,000,000 board feet of hardwood lumber was allotted to the furniture industry on September 5. This is mill run stock not needed in other programs.

Plumbing, Heating and Cooking Equipment.—Eight additional limitation orders governing production of plumbing, heating and cooking equipment were amended August 30 to indicate specifically in the orders themselves that the products they cover are subject to the "spot authorization" procedure established August 15. The eight orders cover: commercial dishwashers (L-248); commercial cooking, food and plate warming equipment (L-182); water heaters (L-185); oil burners (L-74); cast iron boilers (L-187); plumbing and heating tanks (L-199); coal stokers (L-75), and domestic cooking appliances and heating stoves (L-23-c).

Stokers.—Material was authorized September 12 for the production of 37,500 coal stokers of the domestic type during the fourth quarter of 1944. It will take about two months to resume production.

Sugar.—Slightly larger allotments of sugar for prisons, asylums and other institutions of involuntary confinement were provided through amendment 6 to supplement 1, R.O. 5, August 22. The additional sugar will take care of the baking operations of these institutional users. The sugar allowance for Group II users is thus raised from .03 to .04 lb. per person.

Amendment 78, August 18, affects allotments and bases for new institutional users. Amendment 79, August 29, requires any user who wishes to obtain an adjustment for meat allowance for the September-October period to make application for such adjustment.

Water Heaters.—Through Order 1-185, amended August 29, it is now possible for hospitals to obtain prewar types of water heaters.

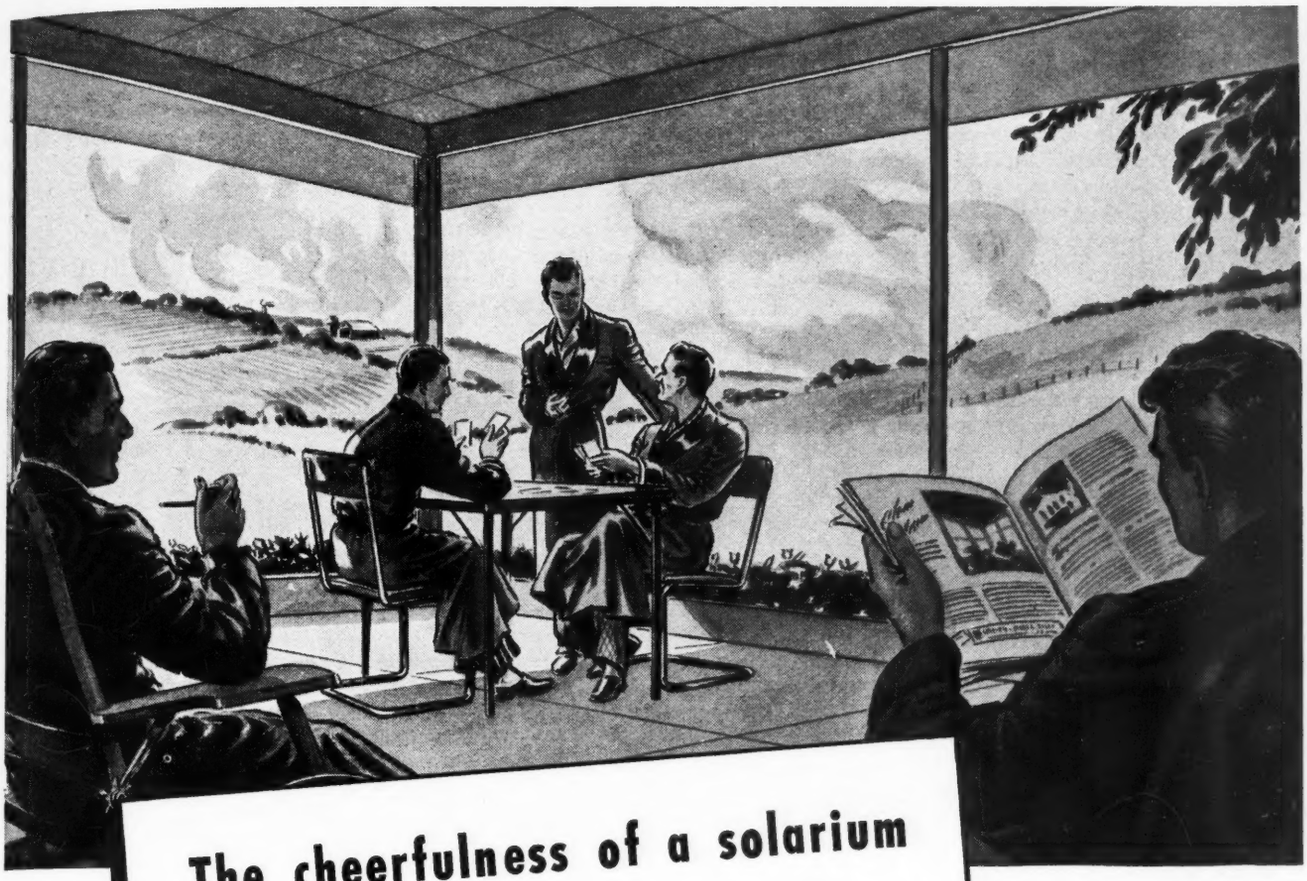
Skinlike Plastic Helps Restore War Veterans' Features

A new elastic plastic that is both flexible and translucent is being used at the U. S. Naval Hospital, Bethesda, Md., and Walter Reed Hospital, Washington, D. C., to restore normal features to war veterans who have lost an ear, nose, chin or fingertip.

Dr. Stanley D. Tylman, professor at the University of Illinois dental college, perfected the new material. The plastic has a texture similar to skin and is finished to a paper edge to hide its joining with living tissue. Skin tones for all complexion types are incorporated right into the plastic and tiny veins and arteries are added superficially. The plastic, which can be made either solid or hollow, is colorfast and washable.

Campaign Fund Oversubscribed

In a ten day campaign Silver Cross Hospital, Joliet, Ill., raised $70,000 for a school of nursing building fund. The goal was $50,000 which the hospital sought as its share of an estimated cost of $160,000 for a two story and ground floor addition for which F.W.A. allotted $110,000. Construction of the new addition was begun in September.



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Thermopane presents no unusual installation problem. It fits into a modified single sash, just like a single pane of regular glass. You leave it up all year—there's no extra glass to put up or take down.

Talk with your architect about Thermopane when you discuss your building plans with him. And write us for information on this new, practical way to get both *daylight* and *full visibility* through an insulated area. Libbey·Owens·Ford Glass Company, 20104 Nicholas Building, Toledo 3, Ohio.

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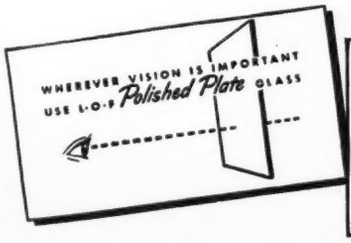

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$5000 Raised for Nebraska Surgical Plan

By the end of August more than $5000 had been subscribed by members of the Omaha-Douglas County Medical Society toward the fund needed to establish the Nebraska Surgical Plan, a new prepayment service. It is being organized as a companion service to the Nebraska Blue Cross plan.

The new plan will offer surgical, obstetric, pathologic, x-ray and anesthesia benefits to subscribers at moderate fees, according to a preliminary announcement. It is hoped to begin operations by October 15. The board consists of six physicians and three laymen, four of whom are also Blue Cross directors. Neither medical conditions nor house calls will be covered.

Premiums are $0.75 for individuals, $1.50 for two persons and $2 for family groups of any number, with an enrollment fee of $1. Obstetric care is available only under the family contract.

While policy determination and settlement of claims will be entirely separate, sales and collections will be made by the Blue Cross and J. H. Pfeiffer, executive director of the Blue Cross plan, is also executive director of the surgical plan.

While a schedule of fees payable to surgeons has been adopted, the surgeon can make additional charges.

Quick Freezing of Germs Is Success

A three year test made by the University of Michigan School of Medicine has resulted in a quick-freeze method of keeping disease germs alive, thereby releasing more animals for scientific work. The previous system of injecting germs into mice or guinea pigs necessitated the drawing off of the serum in a few days or weeks. Dr. Malcolm H. Soule, bacteriology professor and chairman of the hygienic laboratory, tested brain fever, chronic cold sore and meningitis germs in two special refrigeration units and found the germs were just as potent at the end of 968 days as they were at the start.

Open Course in Hospital Standards

An evening course in standards of quality of hospital supplies has been inaugurated at Columbia University, with the opening of the winter session. Conducted by Dewey H. Palmer, research director of the Hospital Bureau of Standards and Supplies, the course deals with the quality and service factors that contribute to economy in the purchase and use of hospital supplies and equipment. It is open to all persons who are preparing for or are employed in administrative positions in hospitals.

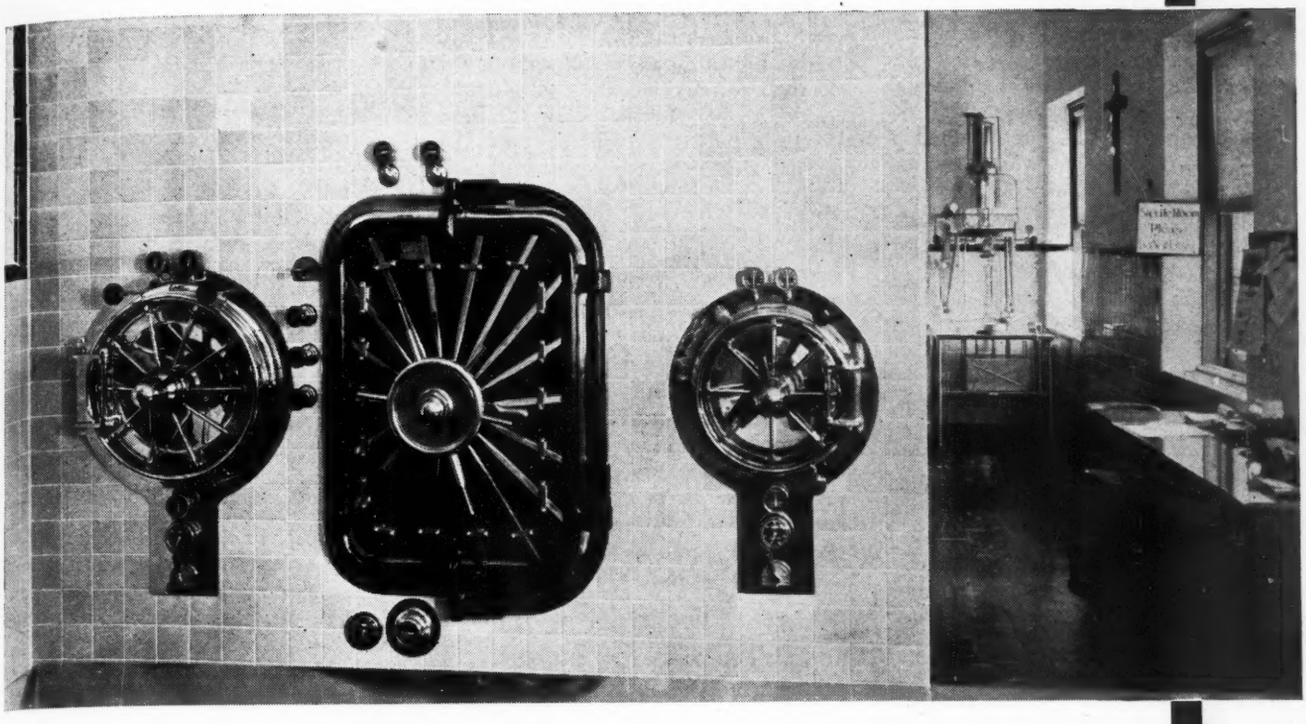
New Penicillin Method for Gonorrhea Patients

WASHINGTON, D. C.—Results of Army medical experiments in which 64 out of 65 men suffering from gonorrhea were cured by single injections of penicillin were announced September 1 by the War Department. Subsequent tests on larger groups of patients have borne out the initial results.

A report on the experimental work telling of the results obtained when penicillin particles were suspended in a mixture of peanut oil and beeswax has been submitted. The effect of the use of the drug in the oil-wax mixture was to make possible its retention in the blood stream over a longer period of time and thus to reduce substantially the dosage that otherwise would have been required.

Methods now generally in use require large doses of penicillin frequently injected with considerable discomfort to the patient. The oil-wax mixture tends to retain the amount of the drug administered by one injection long enough to destroy the disease organism.

Brig. Gen. Hugh J. Morgan, director of the Medical Consultant Division of the Office of the Surgeon General, said that the new method is of fundamental importance and predicted that the results of recent tests on one disease can be carried over to the treatment of others.



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Chicago Council Changes By-Laws

A new constitution and by-laws for the Chicago Hospital Council were adopted on September 20. This eliminates the administrators' section and limits council activities to those hospitals that are regular dues-paying members.

Each hospital is to be represented by three persons, a trustee, a medical staff member and the administrator. In addition, all other trustees, staff members and members of the administrative force are made associate members of the council. Also, certain interested citizens or representatives of interested organizations may be elected to associate membership.

The council will have a chairman of the board who must not be a hospital administrator. He will preside at the annual meetings and at all board meetings. There will be a president of the council who must be a hospital administrator who will preside at all monthly meetings. Forty-seven hospitals in Chicago and neighboring communities are now members of the council.

At the same meeting a plan was presented and approved by a committee of the council to require every hospital that offers obstetric service to keep at least 10 units of plasma on hand at all times. In addition, a program is being worked out to provide red blood cells to all hospitals. These will be processed at the serum center at Michael Reese Hospital and distributed from three depots which will be manned twenty-hours hours a day. Red cells can be kept for five days before being discarded. It is believed that by injecting plasma followed by red cells the equivalent of whole blood transfusions can be achieved. Only the 0, or universal, red cells will be used. A nominal charge will be made sufficient to cover the cost.

New Science Journal Issued

A new quarterly, the *Journal of Parenteral Therapy,* appeared on September 21 as a product of Science Publications Council, New York, with free distribution to surgeons and hospital executives by a grant from Hospital Liquids, Inc., Chicago. In an announcement in the first issue the directors of this company state that "we have reserved absolutely no editorial authority or responsibility for the new journal."

Hospital Closes for Duration

Since the government has stopped operation of gold and silver mines during the war, Tonopah Mines Hospital, Tonopah, Nev., has closed for the duration.

Walter Reed Hospital Starts Music Project

An institute of applied music at Walter Reed General Hospital, Washington, D. C., has been authorized by the surgeon general of the Army to test the potentialities of music as an adjunct to medicine, it was stated August 28.

A group of professional musicians comprises the institute, under the direction of Frances Paperte, a former member of the Chicago Opera Company and soloist with the New York Philharmonic and Cincinnati Symphony orchestras.

The institute works in close collaboration with Army psychiatrists to test the effect of music in certain types of mental and nervous disorders.

"Music as an aid to treatment has been tried before," Miss Paperte stated, "but it has never been properly or adequately controlled nor has its application been evaluated scientifically."

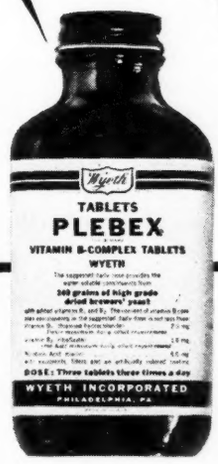
The music in this experiment will be regarded solely as an aid in treatment and not as entertainment or recreation. It will be presented by the highest type of professional musicians.

All music will be checked against a table of variables and applied in a predetermined manner subject to the requirements of the physician. Probability curves have been charted and will be checked against actual results.

Advance Notice to Hospitals

New, Convenient Dosage Forms of Plebex and Bepron Now Available

In response to repeated requests from physicians, Wyeth is now supplying these two popular prescription products in new, convenient dosage form:



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Sheldon Addresses Physical Therapists

The Navy has today approximately 12,000 medical officers as against 1000 in December 1941, R/A Luther Sheldon, assistant chief of the Bureau of Medicine and Surgery, told the American Congress of Physical Therapy at Cleveland on September 7. The Navy is still far short of the number needed to fill with adequacy the billets, afloat and ashore.

Other speakers included Dr. Walter J. Zeiter, chief of the physical therapy department of the Cleveland Clinic, who is executive director of the congress; Capt. A. B. C. Knudson, Veterans Administration; Dr. William H. Schmidt of Philadelphia, and Capt. Charles F. Behrens, U. S. Navy.

Captain Knudson urged all physicians, surgeons and psychiatrists to become more familiar with physical therapy services which may supplement their present ability to deal with disabled persons. He cited the great value of various forms of hydrotherapy in the treatment of insomnia, extreme excitability and similar conditions.

Need for the establishment of rehabilitation centers in many of the nation's communities was stressed by Bell Greve, executive secretary of the Cleveland Rehabilitation Center, Dr. Shelby Granville and Doctor Zeiter.

"Earthquake" Breaks Water Mains in Hospital

Three sub-street floors at Reconstruction Hospital, New York City, were flooded by a water main broken as a result of earth tremors September 11. Damage was estimated at $100,000 to medical supplies and therapeutic equipment made irreplaceable by the war. No emergency cases were in the building at the time and the main hospital unit was untouched. The hospital's gas line was shut off by the city water department and an emergency electric cable was erected, but there was no interruption in the flow of power. Dr. William B. Talbot, medical superintendent of the hospital, stated that as many as possible of the damaged diathermy machines, ultraviolet lamps, radiant heat lamps and drugs would be salvaged.

Demands Ouster of Hospital Head

In an apparent attempt to make political capital of the escape of two inmates from Norwich State Hospital, Norwich, Conn., the state's attorney last month demanded the ouster of Dr. William A. Bryan. Doctor Bryan reported that the institution was understaffed and that the wards for the criminal insane were not of maximum security.

H.I.A. Adds Members

Several organizations, representing varied commercial fields, have been added to the membership of the Hospital Industries Association, it has been announced by the board of directors. The new members are: A. M. Clark Company, Chicago; *Institutions Magazine,* Chicago; Leon S. Rundle and Son, Chicago; Safety Gas Machine Company, Chicago; St. Marys Woolen Manufacturing Company, St. Marys, Ohio; Colt's Patent Fire Arms Manufacturing Company, Hartford, Conn.; Anstice Company, Rochester, N. Y.; John Van Range Company, Cincinnati; C. R. Bard, Inc., New York City; Hoffmann-LaRoche, Inc., Nutley, N. J.; Cutter Laboratories, Chicago; Horner Woolen Mills Company, Eaton Rapids, Mich.; C. V. Mosby Company, St. Louis; American Safety Razor Corporation, Brooklyn, N. Y.; Westinghouse Electric and Manufacturing Company, Baltimore; International Nickel Company, Inc., New York.

Norwegian Women Defy Nazis

Because Norwegian women have refused to enter German service in Norway, German war hospitals in Norway are now being staffed chiefly by Hitler Jugend girls aged 14 to 18. The girls must stay in Norway for one year to make their "war contribution."

MEET a hard-hitting, quick-thinking team that's ready to go to work for *you* . . . ready to bring you new services on a nation-wide scale.

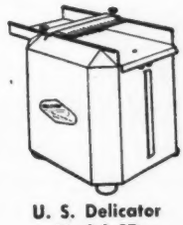
Here's an important step in our Book of Plans—a team of newly organized, coast-to-coast sales and service staffs . . . a team composed of specially trained, experienced men who can help you select the right type of food equipment, bring you up-to-the-minute merchandising assistance, offer you better, faster service and servicing, aid you in processing your priority requests locally.

The team has an expanded line to show you, for U. S. is now the exclusive distributor of the famous "ENTERPRISE" meat choppers and coffee mills—a 78-year-old name known everywhere for its high quality.

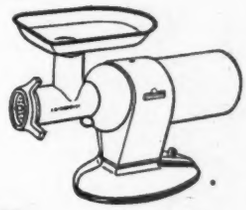
U.S.—ENTERPRISE service facilities have been greatly expanded. Consult your local phone directory for location of nearest office or drop us a post-card at La Porte. We'll help you as promptly as possible. This new team is now in action—watch how fast it travels.

Right now we are still engaged in war production. But as soon as possible, other steps in our plan will unfold. Watch for them, and remember, *now* "U. S." covers the U. S.

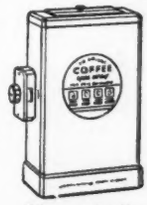
U. S. Slicer
Model GC



U. S. Delicator
Model SD



"Enterprise"
Meat Chopper—2512



"Enterprise"
Coffee Mill—63A

THESE MACHINES ARE AVAILABLE ON APPROVED ORDERS.

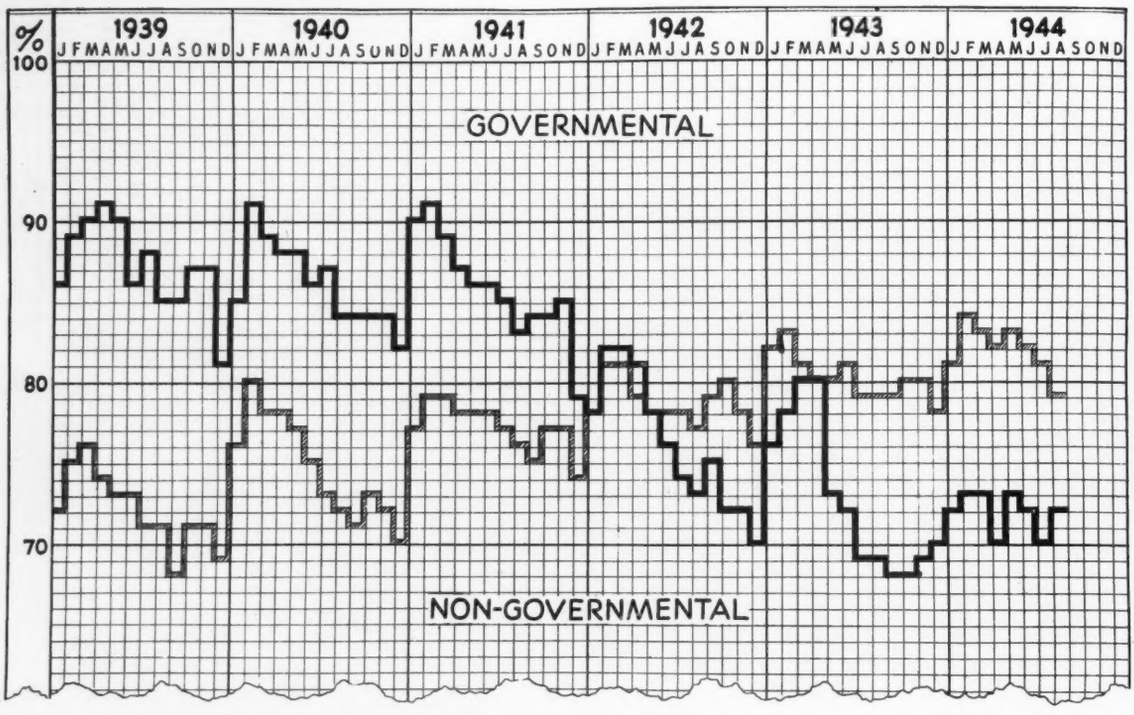
U S SLICERS

U. S. SLICING MACHINE CO.

Quality Food Machines

La Porte, Indiana

Voluntary Hospital Occupancy Drops



Occupancy in non-governmental general hospitals dropped off in August to the lowest point it has had this year, although in the governmental general hospitals it went up somewhat.

Thirty-four new hospital construction projects were announced from August 21 to September 18 with a net total value of $8,797,000. This brought the year-to-date total to $75,924,000 compared to a net total for the same period of last year of $80,150,000.

Nearly half of the total reported for the recent period was for two large rebuildings in Washington, D. C.